The North American Menopause Society

Membership Application

All health professionals with an interest in the many issues affecting women as they approach menopause and beyond are invited to apply for membership in The North American Menopause Society (NAMS) by completing both sides of this form. This information will be used only to contact you regarding your membership.

Last Name | First Name | Middle Initial

Credentials (eg, MD, PhD, RN, NP)

Address

Street/P.O. Box | City

State/Province | ZIP/Postal Code | Country

Telephone | Fax

Email Addresss

As a member, I agree to support the Mission and to further the efforts of the Society. I have completed the reverse side of this form, and have enclosed payment of annual dues for the member category indicated below.

Signature of Applicant | Date

Member Category	Annual Dues (Jan.-Dec.)	Half-Year Dues (July-Dec.)	Amount Enclosed
❍ Active Member	$275.00	$200.00	$_____
❍ Associate Member (student, resident,fellow)	$160.00	$155.00	$_____

Help make a difference in women's lives through a tax-deductible donation. NAMS is a §501(c)(3) nonprofit organization (tax ID 34-1604749). $_____

Total $_____

Method of Payment

❍ Check (in U.S. funds) enclosed, made payable to: **The North American Menopause Society**

❍ VISA ❍ MasterCard

❍ American Express ❍ Discover

Cardholder's City | State | ZIP/Postal Code

Card Number | Expiration Date

CVS/CW2 (security code found on credit card)

Signature

7/16

NAMS
The North American Menopause Society

Please provide the following information, allowing NAMS to better serve the needs of its members.

Profession (choose only one):

- ❍ Administrator
- ❍ Educator
- ❍ Exercise Specialist
- ❍ Healthcare Industry
- ❍ Mental Health Professional
- ❍ Nurse
- ❍ Nurse Practitioner
- ❍ Nurse Midwife
- ❍ Nutritionist
- ❍ Pharmacist
- ❍ Physician
- ❍ Physician Assistant
- ❍ Publishing/Writing
- ❍ Researcher
- ❍ Other:_____

Primarily involved in (choose only one):

- ❍ Clinical Practice
- ❍ Research
- ❍ Other:_____

Speciality (choose only one):

- ❍ Menopause
- ❍ Obstetrics/Gynecology
- ❍ Gynecology
- ❍ Reproductive Endocrinology
- ❍ Endocrinology
- ❍ Geriatrics
- ❍ Family Practice
- ❍ Internal Medicine
- ❍ Cardiology
- ❍ Mental Health
- ❍ Other:_____
- ❍ Urology
- ❍ Public Health
- ❍ Radiology
- ❍ Rheumatology
- ❍ Women's Health
- ❍ Bone Health
- ❍ Oncology
- ❍ Fitness
- ❍ Nutrition

NAMS occasionally rents the names and postal addresses of its members to third parties for educational mailings, provided the contents are approved by the NAMS Board of Trustees. Do you wish to receive these mailings?

❍ Yes ❍ No

Do you wish to receive the following e-mails from NAMS?

- ❍ General NAMS news and notices
- ❍ *First to Know*® e-newsletter (latest, breaking research news and menopause information with expert commentary)
- ❍ *Menopause e-Consult*® e-newsletter (clinical questions and cases with expert commentary)
- ❍ *Menopause Care Updates* e-newsletter (summaries and in-depth commentaries on recent scientific articles that inform and influence clinical menopause practice)

Mail to:
The North American Menopause Society
30100 Chagrin Blvd., Suite 210
Pepper Pike, OH 44124
USA

Telephone 440/442-7550
Fax 440/442-2660
Email info@menopause.org
Website www.menopause.org

Please complete the following:

1. **Do you have a valid and unrestricted license for clinical practice?**
   ❍ Yes ❍ No ❍ Not applicable

2. **Do you have a valid and unrestricted DEA Registration Number?**
   ❍ Yes ❍ No ❍ Not applicable

3. **Have you ever been denied membership or reappointment to the medical staff of any hospital or have your privileges ever been suspended, curtailed, or revoked?**
   ❍ Yes ❍ No ❍ Not applicable

4. **Have you ever been: (i) convicted of healthcare fraud or a healthcare-related crime; (ii) suspended, sanctioned, restricted, or excluded from participating in any private, federal, or state health insurance program; (iii) convicted of theft or embezzlement relating to a healthcare program; (iv) convicted of any crime in the course and scope of your professional employment?**
   ❍ Yes ❍ No

5. **Have any adverse circumstances occurred that prevent you from obtaining malpractice insurance?**
   ❍ Yes ❍ No ❍ Not applicable

6. **Have you ever been convicted of a felony?**
   ❍ Yes ❍ No ❍ Not applicable

If you answered "No" to questions 1 or 2 or "Yes" to any of questions 3–6, please explain:

_____

_____

_____

_____
Name (please print)

_____
Signature Date

Please indicate if you would like your name to be added to the NAMS Website "Find a Menopause Practitioner" list:

- ❍ No, please do not include me in the list.
- ❍ Yes, list me using the information on this application.
- ❍ Yes, list me using the following contact information:

_____
Address

_____
City, State, Zip/Postal Code, Country

_____
Telephone