APPLICATION

BIOGRAPHICAL DATA

First Name:	Middle Initial:	Last Name:	Suffix:
Degrees/Certifications:			Gender: O M O F
Contact Information (Add This is my: •Professional Add		f Virginia)	
Address:			
City:	State:	Zip Code:	
Telephone: ()	Fax: ()	*E-mail:	
	, , ,	ions. E-mail addresses will be used to provid Send me snail mail instead pleas	

CERTIFICATION DATA

Please check the following certifications that may apply to you:

OABSM O ABDSM O BSM ORPSGT OABMS-Sleep

MEMBERSHIP CLASSIFICATION (please check the membership category for which you are applying)

Physician Membership: Individuals possess a MD, DO, PhD, DDS/DMD, or other doctoral degree in sleep disorders medicine. Dues for Physician Members are \$115.

OALLIED SLEEP PROFESSIONAL MEMBERSHIP: Individuals whose primary employment is in the sleep medicine profession, such as polysomnographic technologists and technicians, nurse practitioners and physician assistants.

Dues for Allied Sleep Professional Members are \$65.

Affiliate Membership: Individuals with special training in the healthcare field, such as sleep center managers and respiratory therapists, who are practicing or are interested in sleep medicine.

Dues for Affiliate members are \$65.

OSTUDENT MEMBERSHIP: Student membership is limited to a maximum of two years. Students must re-apply on an annual basis. Dues for Students members are \$35 (please provide program enrollment verification).

METHOD OF PAYMENT

- OCREDIT CARDS: We accept MasterCard, American Express and Visa. Pay online at www.vasleepmedicine.com
- OCHECKS: Make checks payable to: Virginia Academy of Sleep Medicine and please mail payment to:

Virginia Academy of Sleep Medicine 2821 Emerywood Parkway, Suite 200, Richmond, VA 23294

