



1215 Anthony Avenue  
Columbia, SC 29201

## Membership Application

Full Name with Title: \_\_\_\_\_

Office Name: \_\_\_\_\_

Preferred Address:  Work  Home \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Specialty or Interest: \_\_\_\_\_ No. Years in Practice: \_\_\_\_\_

License Type \_\_\_\_\_ State/License #: \_\_\_\_\_ Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Select Membership Category:

*Membership with the SC Neurological Association runs calendar year January 1 to December 31.*

\$100 Physician Type of Physician:  Neurologist  Other \_\_\_\_\_

\$100 Nurse  \$100 Physician Assistant  \$100 Physical/Occupational/Speech Therapist

Office Practice/Administrator –\$100  Resident/Student –No Cost

### Payment:

Check (Payable to: SC Neurological Association)  Visa  MC  AMEX

Card Number \_\_\_\_\_ Expiration \_\_\_\_\_ CVV \_\_\_\_\_

Cardholder Name and Billing Address (if different) \_\_\_\_\_

Billing Address \_\_\_\_\_

Signature \_\_\_\_\_