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_____