SOUTH CAROLINA NEUROLOGICAL ASSOCIATION (SCNA)
MEMBERSHIP APPLICATION FORM

PLEASE PRINT OR TYPE. DATE: ____/____/____

FULL NAME with TITLES: _____

OFFICE NAME: _____

ADDRESS: _____
Mailing Address City State Zip

WORK PHONE: _____ FAX: _____

E-MAIL: _____

HOME ADDRESS: _____ HOME PHONE: _____
Mailing Address City State Zip

SPECIALTY: _____ PREFERRED MAILING ADDRESS: ❑ Home ❑ Office

LOCAL, STATE OR NATIONAL & MEDICAL MEMBERSHIPS: (Please list any state office held.)

_____

S.C. LICENSE #: _____ DATE ISSUED: _____ NO. YEARS IN PRACTICE: _____

MEDICAL SCHOOL ATTENDED: _____
City & State

DEGREE(S): _____ DATE OF GRADUATION: _____

TEACHING APPOINTMENTS: _____ HOSPITAL TRAINING: _____

MEMBERSHIP ON HOSPITAL STAFFS: *(Past and present in chronological order beginning with most recent.)*

Institution	Address	Department	Inclusive Dates From – To	Office Held

OVER

I do hereby certify that all of the information furnished by me is true and correct.

Date: _____ Applicant's Signature: _____

Mail your completed application with your dues payment in the amount of $100.00 to:

SCNA
1215 Anthony Ave
Columbia, SC 29201

OFFICE USE ONLY

Date received: _____ Amount paid: _____ Check number: _____

The Board of Censors has reviewed this application and makes the following recommendations:

MEMBERSHIP: ❑ Accepted ❑ Deferred ❑ Declined

STATUS: ❑ Probationary ❑ Permanent

Reason for deferment or rejection: _____

_____ _____
Secretary/Treasurer Date