

Membership Application

Society of Interventional Pain Management Surgery Centers

The Voice of Interventional Pain Management Ambulatory Surgery Centers



Please type or print your information clearly

When completed, mail to: SIPMS, 81 Lakeview Drive, Paducah, KY 42001 or Fax: (270) 554-5394

A PDF version of this form is available online at www.sipms.org

CENTER NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

TYPE OF CENTER

- Single Specialty (IPM)
- Predominantly Single Specialty (IPM)
- Multi-specialty
- Other _____

TYPE OF OWNERSHIP

- Physician owned
- Corporate owned
- Hospital collaboration
- Other _____

MEDICAL DIRECTOR _____ ADMINISTRATOR _____

NUMBER OF SURGERY CENTERS: _____ NUMBER OF PHYSICIANS: _____ NUMBER OF O.R. ROOMS: _____

NUMBER OF INTERVENTIONAL PROCEDURES PERFORMED IN 2005
 <1,000 1,000–1,459 1,500–1,999 2,000–2,999 3,000–3,999 4,000–5,000 Other _____

Membership Type

SURGERY CENTER

Center memberships include complimentary individual memberships for 2–25 members of staff

- \$25,000 Life Member for SIPMS (fee is per center) with yearly dues of \$5,000
—includes membership for 25 staff members
- \$5,000/year Center is 100% IPM and does 1000+ IPM procedures a year
—includes membership for 5 staff members
- \$2,000/year Center does fewer than 1000 IPM procedures a year
—includes membership for 2 staff members

for surgery center applications:
Attach list of individuals to be named members on a separate sheet(s) of paper and submit with application (up to 25, depending on level of membership to the left). Include information asked of individuals (see below) including title and/or degree.

INDIVIDUALS

Annual Membership (physician, administrator, coordinator, nurse) \$500/year

NAME _____ DEGREE (MD, DO, RN, LPN, etc) _____

POSITION _____

ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ EMAIL _____

SPECIALTY DESIGNATION: 09 Interventional Pain Management 72 Pain Medicine Other _____

Method of Payment

MASTERCARD VISA AMERICAN EXPRESS DISCOVER CHECK (Enclosed, Payable to ASIPP) CHECK NUMBER _____

CREDIT CARD NUMBER _____ EXPIRATION DATE _____ NAME ON CARD _____

AUTHORIZED SIGNATURE (required on all credit card orders) _____