SCCM Chapter Membership Application

SCCM Headquarters
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Chapters provide a vehicle for members to exchange information, network with local critical care practitioners, and discuss the impact of national issues that affect their communities.

To join an SCCM chapter complete the following online application or call SCCM Customer Service at **+1 847 827-6888.** If you are not a member of SCCM and would like to join both the national society and a local chapter, please complete an SCCM **membership application.**

Personal Information

Prefix First Name Middle Initial Last Name (Surname) SCCM Member ID

Designation (MD, RN, PharmD, etc.) Profession

Institution Name Title

Address

Office Number/Street/Suite ❍ Preferred City/State/Province Zip Country

Home Number/Street/Suite ❍ Preferred City/State/Province Zip Country

Phone/Email

Business Phone Number ❍ Preferred Business Email ❍ Preferred

Home Phone Number ❍ Preferred Home Email ❍ Preferred

Certifications

Board Certification(s)/License(s) & Year: _____

Subspecialty Board & Year: _____

Chapter Membership Fees:

A full membership for any chapter is $45.00. Chapter membership is free for anyone currently in training (fellows, residents and students). Please indicate which membership category applies to you and select which chapter you would like to join.

❍ Full membership ❍ In-Training membership

Chapters:

❍ Baltimore Chapter
❍ Carolinas/Virginias Chapter (North Carolina, South Carolina, Virginia and West Virginia)
❍ Michigan Chapter
❍ New Jersey Chapter
❍ New Mexico Chapter
❍ Northeast Chapter (Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont)
❍ North Central Chapter (Iowa, Minnesota, North Dakota, South Dakota, Wisconsin)
❍ Ohio Chapter
❍ Oregon Chapter
❍ Pennsylvania Chapter
❍ Southeast Chapter (Arkansas, Louisiana, Kentucky, Tennessee, Mississippi, Alabama, Georgia)
❍ Texas Chapter

In-Training Information *(Applicable to fellows, residents and students)*

NAME OF PROGRAM DIRECTOR: _____

INSTITUTION: _____

DATES OF TRAINING: START (MM/DD/YYYY) _____ END (MM/DD/YYYY) _____

Payment Options: Credit Card: ❍ DISCOVER ❍ VISA ❍ MasterCard ❍ American Express

I authorize the Society of Critical Care Medicine to charge my fees to the following account:

Cardholder Name: _____ Expiration Date: _____

Card Number: _____ Date: _____

Reset Form **Submit by Email**

Society of Critical Care Medicine
The Intensive Care Professionals

Right Care Right Now