

American Gastroenterological Association APPLICATION

**NURSE/ALLIED
HEALTH PROFESSIONAL**

CORPORATE AFFILIATE

DATE _____

Province _____ Country _____

Application Fee: \$40 (Payable with application.)

Home Phone _____

Please check the appropriate box:

Home Fax _____

NURSE/ALLIED HEALTH PROFESSIONAL MEMBER (\$175/YEAR)

Optional Benefits

- Add *Gastroenterology* and *Gastroenterology Online* (\$165/year)
 Add *Clinical Gastroenterology and Hepatology* (\$40/year)

CORPORATE AFFILIATE MEMBER (\$300/YEAR)

Optional Benefits

- Add *Gastroenterology* and *Gastroenterology Online* (\$165/year, US; \$255/year, International)
 Add *Clinical Gastroenterology and Hepatology* (\$40/year, US; \$65/year, International)

I. PERSONAL INFORMATION

First Name _____ Middle Name _____

Last Name _____

Suffix _____ Job Title _____

Current Degree

M.D. or Equivalent Ph.D. D.O. D.V.M.

Other _____

Preferred Mailing Address Home Work

Work Address

Address 1 _____

Address 2 _____

Address 3 _____

City _____ State _____ Zip _____

Province _____ Country _____

Work Phone _____

Work Fax _____

Email Address _____

Company URL _____

Home Address

Address 1 _____

Address 2 _____

Address 3 _____

City _____ State _____ Zip _____

II. NURSE/ALLIED HEALTH PROFESSIONAL MEMBER APPLICANTS ONLY

Please check the appropriate box(es) regarding your profession:

- Gastroenterology Registered Nurse
 Certified Gastroenterology Associate
 Certified Gastroenterology LPN/LVN
 Certified Gastroenterology Technician or Technologist
 Dietician
 Certified Diabetes Educator
 Other _____

Education

Academic/College _____

Degree _____ Date Graduated _____

Other _____

Degree _____ Date Graduated _____

Further Training

Institution _____

Position(s) or Course Subjects _____

Inclusive Dates _____

Institution _____

Position(s) or Course Subjects _____

Inclusive Dates _____

Institution _____

Position(s) or Course Subjects _____

Inclusive Dates _____

Other Association Memberships

AASLD ACG AMA ASGE GRG NASPGN SSAT

III. CORPORATE AFFILIATE MEMBER APPLICANTS ONLY

Employer's Name _____

Position/Title _____

(OVER)

Affiliation to Gastroenterology

Please provide a brief description of your affiliation to gastroenterology.

Number of years you have had this affiliation. _____

What percentage of your professional time is spent with gastroenterologists? _____

What proportion of that time is spent interacting with gastroenterologists in the following areas:

Private/Clinical Practice _____ %

Teaching _____ %

Research _____ %

Other _____ %

(Specify _____)

IV. PAYMENT

Pay application fee only. Do not include membership dues, subscriptions or registration fees with application. The application fee can be paid by check (payable to AGA in US dollars) or credit card and must be submitted with the application. You will be invoiced for prorated membership dues and other items after you are formally accepted as a member. However, if you do not want to be invoiced, you may indicate this preference below and your membership dues will be automatically charged to your credit card.

Credit Card Payment Form

I authorize AGA to automatically charge my prorated dues payment to my credit card.

VISA Mastercard American Express

Name on Card _____

Account Number _____

Expiration Date _____ Amount _____

Signature _____

Submit the completed application form, along with a check or a completed credit card payment form for the application fee to:

AGA Member Services Department
4930 Del Ray Avenue
Bethesda, MD 20814

