



Date: _____

Name: _____ Degrees: _____
(Please Print)

Mailing Address: _____
 Office Home

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Home: _____ Cell: _____

Fax: _____ E-Mail _____

Membership Category (*check one*) \$50 Doctoral Level
 \$30 Other Health Professionals
 \$10 Resident/Student

Please help us complete your file by checking the appropriate boxes.

PROFESSIONAL DISCIPLINE OR SPECIALTY (*CHECK ONE*)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anatomy | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Pharmacology |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatric |
| <input type="checkbox"/> Behavioral Science | <input type="checkbox"/> Neurology | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Biomedical Engineering | <input type="checkbox"/> Neuroscience | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Clinical Pharmacy | <input type="checkbox"/> Nursing | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Clinical Research | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Oncology | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other (<i>specify</i>) _____ | | |

Specialization By Work Function (*check all that apply*)

- Administrator Educator Clinician Researcher Consultant Other (*specify*) _____

Current Practice Setting

- Educational or Research Institution Governmental or community health agency Hospice
 Hospital Pain clinic Private Practice Other (*specify*) _____

Years of Experience in Pain Management and/or Research

Less than 1 year 1 - 3 years 4 - 6 years 7 - 10 years 11 - 15 years More than 15 years

Other Association Memberships

American Pain Society International Association for the Study of Pain

Hospital Affiliation (if applicable):

University Affiliation (if applicable):

If a colleague recommended MPS membership to you, please provide his/her name: _____

Payment Information:

Check Visa Master Card American Express

Account Number _____ Expiration ate _____

Card Holders Name _____

Signature _____

Please make checks payable to **MIDWEST PAIN SOCIETY**. Please forward application to:

Midwest Pain Society
ATTN: Cathy Rickert
4700 West Lake Avenue
Glenview, IL 60025-1485
Fax: 847/375-6489