Clinical Associate Membership Information

All of the documents must be submitted for the application to be processed.

Thank you for your interest in the Society of NeuroInterventional Surgery (SNIS). We are pleased to provide you with the attached application, and the following information regarding the Society.

Clinical Associate Membership Requirements

- A non-physician member of the medical profession who has a special interest and competency in neurointerventional surgery, such as a physician assistant, nurse practitioner, radiologic technologist or paramedical professional;
- Professional reference and contact information; and
- Current CV detailing training and professional experience.

Clinical Associate Membership Benefits

- Access to the "Members Only" and "Amenities" Sections of the SNIS website, snisonline.org;
- A subscription to the *Journal of NeuroInterventional Surgery*, the official journal of SNIS;
- Access to SNIS Connect, the members-only online forum;
- A subscription to *The Embolus*, the official newsletter of SNIS;
- Reduced registration fees to SNIS-sponsored meetings and conferences;
- Networking opportunities with fellow experts in this expanding medical specialty;
- A subscription to *Suite Talk*, the official electronic newsletter of SNIS;
- Discounts on SNIS products.

Dues for Clincal Associate membership arecurrently $50.00 a year.

Clinical Associate Membership Documentation Required

- ☐ Completed Application
- ☐ Current CV detailing training and professional experience
- ☐ Professional reference and contact information

Please return all documents to:
SNIS Membership Chairman
12587 Fair Lakes Circle, Suite 353
Fairfax, VA 22033

If you have any questions, please call SNIS Headquarter at **703-691-2272** or Email **info@snisonline.org.**

Please note: All of the documents must be submitted for the application to be processed.

SNIS Society of NeuroInterventional Surgery

Application for Clinical Associate Membership

Please refer to the Clinical Associate Membership Information sheet accompanying this application for full details. Please type or print legibly.

Name_____
First Middle Last Degree

Address Information – List both home and office addresses, and check your *preferred mailing address.*

I prefer that correspondence is sent to my: ☐ Home ☐ Office

HOME

Address

City State Zip

Phone Email

OFFICE

Applicant's Title Institution/Affiliation

Department

Address

City State Zip

Phone Email

Sponsor

Name of Sponsor Institution

Phone Email

Please indicate your profession

☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA) ☐ Radiologic Technologists (RT) ☐ Radiology Practitioner Assistant (RPA)

☐ Registered Nurse (RN) ☐ Other_____

Medical or Graduate Education

Institution Degree Date

I agree to abide by the Bylaws of the SNIS and any revisions thereof:

Applicant's Signature Date