

# The Society for Pediatric Sedation®



**Society for  
Pediatric Sedation**  
Safe and Sound

## MEMBERSHIP APPLICATION

The Society is open to all healthcare providers who are actively involved in the delivery of pediatric sedation and all those who wish to advance the society's mission. Individuals who express an interest in pediatric sedation via clinical practice, research and/or education may be a member of the Society for Pediatric Sedation®.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Title: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Specialty: \_\_\_\_\_

Affiliation: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ City: \_\_\_\_\_

State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### SPECIALTY TYPE (Must choose at least one)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Ambulatory Care | <input type="checkbox"/> Emergency Medicine                         | <input type="checkbox"/> Oral and Maxillofacial Surgery | <input type="checkbox"/> Radiology             |
| <input type="checkbox"/> Anesthesiology  | <input type="checkbox"/> General Surgery                            | <input type="checkbox"/> Oral Surgeons                  | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Cardiology      | <input type="checkbox"/> Hematology/Oncology                        | <input type="checkbox"/> Pain Management                | <input type="checkbox"/> Sedation              |
| <input type="checkbox"/> Child Life      | <input type="checkbox"/> Hospital Medicine                          | <input type="checkbox"/> Pediatric Dentists             | <input type="checkbox"/> Urology               |
| <input type="checkbox"/> Critical Care   | <input type="checkbox"/> Nurse Practitioner (Adv. Practice Nursing) | <input type="checkbox"/> Pulmonology                    |  |
| <input type="checkbox"/> Dentistry       | <input type="checkbox"/> Nursing                                    |   |  |

### MEMBERSHIP CATEGORY

Membership Categories	TIER 1	TIER 2	TIER 3	TIER 4
<input type="checkbox"/> <b>Sustaining Member:</b> Any healthcare provider who meets the physician or allied health categories may join by paying the fee established by the Board of Directors. Membership in this category provides the member with special recognition and privilege as determined by the Board of Directors.	\$200	\$200	\$200	\$200
<input type="checkbox"/> <b>Physician:</b> Licensed physicians with an interest in pediatric sedation may become a member.	\$100	\$50	\$10	\$3
<input type="checkbox"/> <b>Dentist:</b> Any doctor of dental surgery, doctor of dental medicine, pediatric dentists, general dentists and oral surgeons with an interest in pediatric sedation may become a member.	\$100	\$50	\$10	\$3
<input type="checkbox"/> <b>Allied Health/RN:</b> Any licensed healthcare provider who is not a physician may become a member.	\$50	\$25	\$5	\$2
<input type="checkbox"/> <b>Allied Health/Other:</b> Any licensed healthcare provider who is not a physician may become a member.	\$50	\$25	\$5	\$2
<input type="checkbox"/> <b>Associate:</b> Anyone with an interest in the field of pediatric sedation who does not meet the criteria of any other category may become an associate member. Associate members are not eligible to vote or hold office.	\$50	\$25	\$5	\$2
<input type="checkbox"/> <b>Trainee:</b> Any student, resident or healthcare provider involved in a training program may become a member. Trainee Institution: _____ Location: _____ Graduation/Residency Date: _____	\$20	\$10	\$2	\$1

Please visit: <http://www.pedsedation.org/membership/membership-tiers/> to find your tier.

### PAYMENT OPTIONS:

- Check or Money Order Enclosed (US Funds) Made Payable to the **Society for Pediatric Sedation**
- Mastercard  Visa  Discover Expiration Date: \_\_\_\_\_

Card No \_\_\_\_\_ CVV Code: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_ Printed Name on Card \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_ Credit Card Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Society for Pediatric Sedation®**

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