INTERNATIONAL EECP SOCIETY

MEMBERSHIP APPLICATION

Personal Data

Membership Type:

❑ Member *Physician with documented training in EECP therapy and cardiovascular, cerebrovascular, or endovascular disease*

❑ Associate *Nurses, practitioners, technicians, physician assistants, therapists and practice administrators with one recommendation from a member of the society*

First Name | Middle Initial | Last Name

Name Of Practice/Institution | Position/Title

____/____/_____ Birth Date | ❑ Male ❑ Female Gender | _____ NPI#

Preferred Mailing Address

❑ Business Address (Required) | City, State ZIP | Business Phone

❑ Home Address | City, State ZIP | Home Phone

Fax | Cell Phone | Email Address

Professional Background

Currently licensed to practice medicine in country (s) / province (s) of _____ since ____

Percentage of professional time devoted to cardiovascular field _____% since ____

Please check ONE that best describes your primary work setting:

❑ Hospital:Academic ❑ Hospital:Community ❑ Industry/Research ❑ Military ❑ Multispeciality Group

❑ Cardiovascular Group ❑ Cardiovascular Solo Provider ❑ Other *(please specify)* _____

If Cardiovascular Group, please select: ❑ Privately owned ❑ Hospital owned ❑ Insurance company

Area of Specialty

Applicant's Authorization to Release Information

I hereby consent to the release by any hospital, educational institution, governmental agency, physician, professional society, or other person possessing or requiring the same, whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence.

I agree that communications of any nature made to the Society regarding my fitness for membership may be made in confidence and shall not be made available to me under any circumstances. I hereby release from any liability any and all individuals and organizations or their authorized representatives who provide this information in good faith and without malice subject to this consent. I hereby release from all liability the International EECP Society and any and all individuals for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications.

I hereby certify that all information recorded on this application and any attached documents is accurate and supports my qualifications for membership in the International EECP Society for which I now apply. I hereby agree that the International EECP Society may verify any of the above data.

If elected, I agree to conform to the Bylaws of the Society and its Code of Ethics. Information available to me can be found at www.ieecps.org

Signature _____ Date _____

Membership Fee

❑ **Member $50 USD** ❑ **Associate $25 USD**

Payment Method: ❑ Check ❑ Credit Card

❑ VISA ❑ MasterCard ❑ America Express ❑ Discover

Card Number _____ CVV# _____ Expiration Date _____

Mail applications and membership fees to:

International EECP Society
217 Woodbury Rd #594
Woodbury, NY 11797 USA

Phone: +1 516 508 5805
Email: info@ieecps.org
Website: www.ieecps.org

Additional forms can be found on www.IEECPS.org