



# THE PEDIATRIC CARDIAC INTENSIVE CARE SOCIETY

2209 Dickens Rd., Richmond, VA 23230-2005

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## MEMBERSHIP APPLICATION

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First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_ Degree/Title \_\_\_\_\_

Male  Female Preferred Contact Address  Mailing  Billing Date of Birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ City \_\_\_\_\_

State/Country \_\_\_\_\_ State/Country \_\_\_\_\_

Zip/Postal Code \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

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

E-Mail: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of Practice:  Private  University  Government  Other

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

Academic Degrees & Other Professional Certifications With Dates: \_\_\_\_\_

ABA #: \_\_\_\_\_ (Eight Digits)

### I Hereby Make Application For:

**PHYSICIANS**..... \$100

**NURSE ALLIED HEALTH MEMBER**.....\$50  
(Nurses, Fellows in Training, Other  
Non-Physician Medical Personnel)

### SPECIALTY

Cardiac Surgeon  Neonatologist

Cardiologist  Cardiac Nurse

Pediatrician  Cardiac Nurse Practitioner

Intensivist  Other

Specify \_\_\_\_\_

### Payment Options:

Check or Money Order Enclosed (US Funds) Made Payable to: PCICS, 2209 Dickens Rd., Richmond, VA 23230-2005.

AmEx  Mastercard  Visa  Discover

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

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

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

For more information, visit [www.pcics.org](http://www.pcics.org)