



THE PEDIATRIC CARDIAC INTENSIVE CARE SOCIETY

2209 Dickens Rd., Richmond, VA 23230-2005

Phone: 804-565-6398 • Fax: 804-282-0090 • E-mail: greg@societyhq.com • www.pcics.org

MEMBERSHIP APPLICATION

Last Name: _____ First Name: _____ MI: _____ MD DO PhD RN NP
 RRT APN MD-PhD PA Other _____

Preferred Mailing Address: _____

City: _____ State/Country: _____ Zip/Postal Code: _____

Office Phone: _____ Fax: _____ Home Phone: _____

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

E-mail: _____ Title: _____

Hospital Affiliation: _____ University Affiliation: _____

Academic Degrees & Other Professional Certifications With Dates: _____

Specify residencies and fellowships completed with year (or year of anticipated completion): _____

I Hereby Make Application as a:

| | TIER 1 | TIER 2 | TIER 3 | TIER 4 |
|--|--------|--------|--------|--------|
| <input type="checkbox"/> PHYSICIAN | \$150 | \$75 | \$30 | \$5 |
| <input type="checkbox"/> NURSE/ALLIED HEALTH/TRAINEE/RESIDENT/FELLOW (Nurses, Other Non-Physician Medical Personnel) | \$100 | \$50 | \$20 | \$3 |

Please refer to the PCICS Website (www.pcics.org/join/membership-tiers/) to determine your tier.

TOTAL \$ _____

Please check all that apply, or "NA" if none apply

Specialty:

- | | | | | |
|--|---|--|---|-------------------------------------|
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Cardiac Nurse | <input type="checkbox"/> Cardiac Cath Lab Nurse | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Pediatric Cardiologist | <input type="checkbox"/> Cardiovascular Surgeon | <input type="checkbox"/> Cardiac Cath Lab Nurse Practitioner | <input type="checkbox"/> PharmD | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pediatric Cardiac Intensivist | <input type="checkbox"/> CICU Nurse | <input type="checkbox"/> CICU Nurse Practitioner | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pediatric Intensivist | <input type="checkbox"/> PICU Nurse | <input type="checkbox"/> PICU Nurse Practitioner | <input type="checkbox"/> ECMO Specialist | <input type="checkbox"/> _____ |
| | | <input type="checkbox"/> Cardiac Nurse Practitioner | <input type="checkbox"/> Respiratory Therapist | |

Where do you work?:

- CICU CVICU PICU Cardiology step down unit Cardiology floor NICU Pediatric floor NA

Where are cardiac intensive care patients cared for in your hospital?:

- CICU CVICU PICU NICU NA

In your institution, how many beds are there in each unit ("NA" if your hospital does not have the specific unit):

CICU _____ CVICU _____ PICU _____ NICU _____

Would your hospital be interested in having a link to its website on www.pcics.org? Yes No

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