



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

Please refer to the PCICS Website ([www.pcics.org/join/membership-tiers/](http://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"/> PA                    |
| <input type="checkbox"/> Pediatric Cardiac Intensivist | <input type="checkbox"/> CICU Nurse             | <input type="checkbox"/> CICU Nurse Practitioner             | <input type="checkbox"/> Perfusionist           | <input type="checkbox"/> Other - specify _____ |
| <input type="checkbox"/> Pediatric Intensivist         | <input type="checkbox"/> PICU Nurse             | <input type="checkbox"/> PICU Nurse Practitioner             | <input type="checkbox"/> ECMO Specialist        |  |
| <input type="checkbox"/> Pediatric Intensivist         | <input type="checkbox"/> PICU Nurse             | <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](http://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](http://www.pcics.org)