

Name _____ Date _____

Position or Title _____ RN MD PhD RPH Other Credentials _____

Organization _____

Street Address _____

City _____ State _____ Zip _____ Country _____

Work Phone _____ Fax Number _____

E-mail Address** _____

Home Street Address ? same as work _____

City _____ State _____ Zip _____ Country _____

Preferred Mailing Address (Your work address will be listed in the online directory) ? Home ? Work _____

Membership Dues (In US dollars) Please check one

Individual Member: \$100 Student Member: \$30 Evidence of full-time matriculation must be provided Graduate Undergraduate Dean's List _____
University _____ Expected Graduation Date _____

Users Group Alliance Program (\$100 level only)

As a member, you can participate in the Microsoft Health Users Group and Cisco's Community for Connected Health. Please check the box(es) below to register for each group.
 Microsoft HUG Cisco's Community for Connected Health (You are registering for a user group sponsored by Cisco Systems, Inc. and agreeing that Cisco may periodically send you information. All registration data will be shared by HIMSS with Cisco Systems, Inc. For more information on Cisco Systems privacy statement, visit <http://www.cisco.com/web/siteassets/legal/privacy.html>.)

Your Professional Title (Check one.)

Information & Management Systems

- CIO, CTP, VP of IT/IS/MIS/Network
- Director/Manager Data Processing/MIS
- CSO, Director/Manager Info Security/ Site Security
- Director of Management Engineering
- Manager of Management Engineering
- Dir/Mgr of other IT department
- Non-Management
- Systems Analyst
- Programmers/Developers
- Other (please specify) _____

General & Financial Management

- CEO, Chairman, Pres, Exec Dir, Adm, Group Practice Mgr
- COO, Exec VP, Sr VP, VP, Gen Mbr, Asst Administrator
- CFO, VP/Finance, Finance Director, Controller
- VP/Director/Manager of other Admin/ Financial Dept
- Non-Management
- Other (please specify) _____

Clinical Management

- CMO, CMIO, Medical Dir, Chief of Staff
- CNO, CNIO, VP/Director/Manager of Nursing
- Physician
- Nurse
- Registered Pharmacist
- Chief/Dir/Mgr of other Clin Dept/ Lab Srv/Pharmacy
- Other (please specify) _____

Others Allied to the Field

- IT, Business Consultant
- Professor/Educator
- Student
- Programmers/Developers
- Marketing and Sales
- Government Employee/Public Servant
- Non-Management
- Other (please specify) _____

Your Work Site (Check one.)

- Academic Institution
- Ancillary Clinical Service Provider
- Ambulatory Care Facility
- Federal, State or Local Government Office
- Healthcare Consulting Firm
- Home Healthcare Organization
- Hospital, Multi-Hospital System, Integrated Delivery
- Financial, Legal, Investment Firm
- Long Term Care Facility
- Payor, Insurance Company, Managed Care
- Healthcare Vendor
- Other (please specify) _____

How did you hear about HIMSS?

- Promotional Marketing Conference Microsoft Corporation Colleague _____
- Web Site Affiliated Chapter Other _____

Payment

Annual dues in the amount of \$_____ are enclosed. I understand that HIMSS may deposit the enclosed dues pending consideration of this application. In the event the application is not approved, HIMSS will promptly refund my remittance.

Check Enclosed

- American Express Discover MasterCard Visa

Card Number _____ Expiration Date _____

Name on Credit Card (Please Print) _____

Cardholder's Signature _____

Mail or fax payment to:
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230 E., Ohio St., Suite 500
Chicago, IL 60611-3269
Phone: 312.664.4467
Fax: 312.915.9209

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