



INDIVIDUAL Membership Application

Name _____ Today's Date: _____ Date of birth: _____

Position or Title _____ RN MD PhD RPh Other Credentials _____

Organization _____

Mailing Address HOME WORK _____

City _____ State _____ Zip _____ Country _____

Phone HOME WORK CELL _____ Fax Number HOME WORK _____

E-mail Address** PERSONAL WORK UNIVERSITY _____

Membership Dues (Please check one. Membership type and dues submitted must match country of residence including student membership types)

U.S. and CANADA RESIDENTS: Individual Member: \$199 Chapter Only Member \$39 Online Only Member \$39 (no chapter)

INTERNATIONAL RESIDENTS: Africa \$100 Asia Pacific \$100 Europe \$100 Latin America \$100 Middle East \$100

*STUDENT MEMBER: Africa \$30 Asia Pacific \$30 Europe €30 Latin America \$30 Middle East \$30 North America \$30

UNIVERSITY INFORMATION: Graduate Undergraduate University _____ Number of credit hours enrolled _____ Expected Graduation Date _____

**To qualify for student membership you must be enrolled full-time and provide evidence of full-time matriculation. Visit: <http://www.himss.org/membership/student> for full details.*

Chapter Affiliation (US and Canada residents only)

Individual Membership (\$199) and Student membership includes one complimentary chapter. You will not be assigned a chapter unless otherwise specified _____

Your Professional Title (Check one.)

Information & Management Systems <input type="checkbox"/> CIO, VP of IT/IS <input type="checkbox"/> CMIO, CNIO, CCIO <input type="checkbox"/> CTO <input type="checkbox"/> CSO, VP, Dir/Mgr Info Security/Site Security <input type="checkbox"/> Manager Info Security/Site Security <input type="checkbox"/> VP, Dir, Network, Internet, Intranet, Telecom <input type="checkbox"/> Mgr Network, Internet, Intranet, Telecom, <input type="checkbox"/> VP, Director of other IT department <input type="checkbox"/> Manager of other IT department <input type="checkbox"/> VP, Dir. of Management Engineering / Process Improvement <input type="checkbox"/> Non-Management <input type="checkbox"/> Project Manager <input type="checkbox"/> Programmers/Developers <input type="checkbox"/> Senior Staff / Staff <input type="checkbox"/> Systems Analyst	General & Financial Management <input type="checkbox"/> CEO, Chairman, Pres, Exec Dir <input type="checkbox"/> COO, Exec VP, Sr VP, VP, Gen Mbr, Asst Admin <input type="checkbox"/> CFO, VP/Finance, Finance Director, Controller <input type="checkbox"/> VP/Director of Patient Accounting / Billing <input type="checkbox"/> Director/Mgr/Supervisor of other Financial Dept. <input type="checkbox"/> Compliance Officer, Compliance VP/Dir/Mgr <input type="checkbox"/> Mgr/Supervisor of Patient Accounting / Billing <input type="checkbox"/> Non-Mgmt of staff Patient Accting / Billing <input type="checkbox"/> Healthcare Strategist <input type="checkbox"/> Treasury Services/Cash Mgmt/Lock Box <input type="checkbox"/> HSA Product Management <input type="checkbox"/> Senior Staff / Staff	Clinical Management <input type="checkbox"/> CMO, Medical Dir, Chief of Staff <input type="checkbox"/> CNO, VP/Director of Nursing <input type="checkbox"/> Chief/Director of other Clin Dept / Lab Srv / Pharmacy <input type="checkbox"/> Manager of other Clin Dept / Lab Srv / Pharmacy <input type="checkbox"/> Manager of Nursing <input type="checkbox"/> Nurse <input type="checkbox"/> Hospital Based Physician / Hospitalist <input type="checkbox"/> Private Practice Physician <input type="checkbox"/> Physicians Assistant <input type="checkbox"/> Registered Pharmacist <input type="checkbox"/> Senior Staff / Staff	Others Allied to the Field <input type="checkbox"/> IT, Business Consultant <input type="checkbox"/> Professor/Educator <input type="checkbox"/> Student <input type="checkbox"/> Programmers/Developers <input type="checkbox"/> Marketing and Sales <input type="checkbox"/> Government Employee/Public Servant <input type="checkbox"/> Non-Management <input type="checkbox"/> Other (please specify) _____
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Your Work Site (Check one.)

<input type="checkbox"/> Academic Education Institution <input type="checkbox"/> Academic Medical Center <input type="checkbox"/> Ancillary Clinical Service Provider <input type="checkbox"/> IDS/hospital-owned Amb Clinic	<input type="checkbox"/> Bank / Financial Institution <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Community Health Center Clinic <input type="checkbox"/> Federal, State or Local Govt	<input type="checkbox"/> Healthcare Consulting Firm <input type="checkbox"/> Home Healthcare Organization <input type="checkbox"/> Hospital, Multi-Hospital System, Integrated Delivery <input type="checkbox"/> Independent Ambulatory Clinic	<input type="checkbox"/> Financial, Legal, Investment Firm <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Payor, Ins Company, Mngd Care <input type="checkbox"/> Professional Assn / Society	<input type="checkbox"/> Public Health <input type="checkbox"/> Life Sciences <input type="checkbox"/> Vendor <input type="checkbox"/> Other (please specify) _____
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How did you hear about HIMSS?

<input type="checkbox"/> Affiliated Chapter	<input type="checkbox"/> Employer	<input type="checkbox"/> Journal/Article	<input type="checkbox"/> School/Advisor	<input type="checkbox"/> HIMSS Website
<input type="checkbox"/> CISCO	<input type="checkbox"/> Former Member	<input type="checkbox"/> Microsoft	<input type="checkbox"/> Social Networking	<input type="checkbox"/> Colleague _____
<input type="checkbox"/> Conference	<input type="checkbox"/> HIMSS Analytics	<input type="checkbox"/> Ad/Mailing/Email	<input type="checkbox"/> HIMSS Staff	<input type="checkbox"/> Other _____

Payment

Annual dues in the amount of \$ _____ are enclosed.

Check Enclosed
 American Express Discover MasterCard Visa

Card Number _____ Expiration Date _____

Name on Credit Card (Please Print) _____

Cardholder's Signature _____

By mail send payments to: HIMSS 6901 Eagle Way Chicago, IL 60678-1690 Phone: 312.664.4467 Fax: 312.915.9209	By wire: JPMorgan Chase 10 S. Dearborn St Chicago, IL 60603 Swift code: CHASUS33 ABA #: (021000021 WIRE) or (07000013 ACH) Account #: 5300097217
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HIMSS membership dues are not deductible as a charitable contribution but may be deductible as a business expense. To the extent HIMSS engages in lobbying, 1.37% of dues are not deductible as a business expense. Contributions to the HIMSS Foundation are deductible as a charitable contribution for federal income tax purposes to the extent provided by HIMSS Federal Tax ID Number 36-3906745. HIMSS dues are non-refundable and non-transferrable.

** HIMSS regularly sends e-mails describing its products and services. By returning this form, you agree to allow HIMSS to send these promotional e-mails to you. You will have the opportunity to opt out of the e-mail list at your discretion.