Application for 2012 Membership
New York State Society of Sleep Medicine

NYSSSM

ANNUAL DUES STATEMENT

Biographical Information

Last Name: _____

First Name: _____

Middle Initial: _____ Suffix: _____

Degree(s): _____

Date of Birth: ____/____/____ Gender: □ Male □ Female

Address: _____

_____

City: _____ State: _____

Zip: _____

Phone: _____

E-mail address: _____

Membership Classification
(please check all that apply)

Are you renewing your membership?
_____Yes _____No

Doctoral
(MD, DO, PhD) _____ ($50)

Non-Doctoral
(RPSGT, RN, RRT) _____ ($35)

Student
(resident, fellow, intern) _____ ($20)

Corporate _____($100)

NYSSSM Development Fund
(optional) _____($100)

TOTAL: _____

Payment

□ *Check enclosed*. Please send to a check (payable to *New York State Society of Sleep Medicine*) along with this application to:

New York State Society of Sleep Medicine
c/o Shelby Harris, Psy.D., C.BSM
Sleep-Wake Disorders Center
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467

If you have questions about membership, please contact the NYSSSM Membership Chair, Dr. Shelby Harris at slharris@montefiore.org or call 718-920-4841.