

2027 MEMBERSHIP APPLICATION

CONTACT INFORMATION

PREFIX FIRST NAME (GIVEN NAME) MIDDLE NAME LAST NAME (FAMILY NAME) AND SUFFIX

PRIMARY EMAIL (REQUIRED) SECONDARY EMAIL

PRIMARY CONSTITUENCY (SELECT ONE): ☐ BASIC SCIENCE ☐ CLINICAL SCIENCE ☐ CLINICAL PRACTICE

DO YOU CONDUCT RESEARCH?: ☐ YES ☐ NO DO YOU TREAT PATIENTS: ☐ YES ☐ NO

BUSINESS ADDRESS (FOR MEMBER DIRECTORY LISTING)

ORGANIZATION DEPARTMENT/DIVISION

MAILING ADDRESS STREET/PO

CITY STATE/PROVINCE COUNTRY ZIP/POSTAL CODE

TELEPHONE (DAY): COUNTRY CODE/CITY CODE/NUMBER FAX: COUNTRY CODE/CITY CODE/NUMBER

HOME ADDRESS (OPTIONAL)

MAILING ADDRESS STREET/PO APT#

CITY STATE/PROVINCE COUNTRY ZIP/POSTAL CODE

TELEPHONE (DAY): COUNTRY CODE/CITY CODE/NUMBER FAX: COUNTRY CODE/CITY CODE/NUMBER

PRIMARY MAILING ADDRESS: ☐ HOME ☐ BUSINESS

COMPLETE PROFESSIONAL PROFILE ON REVERSE SIDE. →

MEMBERSHIP DUES TERM: JANUARY 1–DECEMBER 31, 2027

See reverse side for membership criteria. See reverse side for a list of Tier 5 and Tier 4 countries.

UNITED STATES (TIER 5)

- ☐ \$360 FULL MEMBER (PRINT JCEM OR ONLINE)
☐ \$185 EARLY CAREER MEMBER
☐ \$40 IN-TRAINING ASSOCIATE MEMBER
☐ \$245 ASSOCIATE MEMBER
☐ \$175 RETIRED MEMBER

INTERNATIONAL (TIER 4)

- ☐ \$349 FULL MEMBER (ONLINE ONLY)
☐ \$419 FULL MEMBER (WITH PRINT JCEM)
☐ \$179 EARLY CAREER MEMBER
☐ \$39 IN-TRAINING ASSOCIATE MEMBER
☐ \$239 ASSOCIATE MEMBER
☐ \$169 RETIRED MEMBER (ONLINE ONLY)
☐ \$204 RETIRED MEMBER (WITH PRINT JCEM)

JOURNAL SUBSCRIPTIONS

All members receive online access to *Endocrinology*, *Journal of Clinical Endocrinology & Metabolism* (JCEM), and *Journal of the Endocrine Society*.

☐ I'D LIKE TO ADD A SUBSCRIPTION TO *ENDOCRINE REVIEWS*:

- ☐ \$109 WITHIN THE US
☐ \$135 INTERNATIONAL
☐ \$186 INTERNATIONAL EXPEDITED
☐ \$20 IN-TRAINING ASSOCIATE (ONLINE ONLY)
☐ \$109 RETIRED

THREE EASY WAYS TO JOIN

ONLINE AT
ENDOCRINE.ORG/JOIN

MAIL COMPLETED FORM TO
ENDOCRINE SOCIETY
P.O. BOX 17020
BALTIMORE, MD
21298-9419

FAX COMPLETED FORM
TO +1.202.736.9704

PAYMENT INFORMATION

DUES \$ _____ + JOURNALS \$ _____ = TOTAL PAYMENT \$ _____

Please enclose a check or money order made payable to "Endocrine Society" in US funds only, drawn on a bank with US branch, or complete credit card information below. If a payment must be refunded and reapplied to a different card, a 5% fee will be deducted from the original charge to offset additional processing costs.

☐ CHECK (ENCLOSED) ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

NAME OF CARDHOLDER (PLEASE PRINT) CARD NUMBER CVV CODE EXPIRATION DATE (MM/YY)

BILLING ADDRESS (IF DIFFERENT FROM ABOVE) BILLING ZIP/POSTAL CODE

SIGNATURE

Your signature authorizes your credit card to be charged for the total payment above. The Endocrine Society reserves the right to charge the correct amount if different from the total payment listed above.

SOURCE CODE: _____

ENDOCRINE SOCIETY MEMBERSHIP CRITERIA

FULL MEMBER

MD, PhD, or global equivalent

EARLY CAREER MEMBER

MD, PhD, or global equivalent
(1-3 years post-training)

IN-TRAINING ASSOCIATE MEMBER

Student, resident, or fellow enrolled in an
endocrinology-related education program

ASSOCIATE MEMBER

Advanced practice provider or other
hormone health and/or science
professional

QUESTIONS?

If you have any questions concerning
your membership application, contact
the Membership Department by phone
at +1.202.971.3646 or 1.888.363.6762,
by fax 1.202.736.9704; or by email at
info@endocrine.org

WORLD BANK INCOME DESIGNATION

TIER 4:

Abkhazia	Greece	Portugal
Akrotiri And	Greenland	Qatar
Dhekelia	Gui	Romania
Åland	Guyana	Russia
American	Hong Kong	Saint
Samoa	Hungary	Barthélemy
Andorra	Iceland	Saint Helena
Anguilla	Ireland	Saint Kitts
Antigua	Isle of Man	And Nevis
Aruba	Israel	Saint Martin
Ascension	Italy	Saint Pierre
Australia	Japan	And
Austria	Jersey	Miquelon
Bahamas	Kuwait	San Marino
Bahrain	Latvia	Saudi Arabia
Barbados	Liechtenstein	Seychelles
Belgium	Lithuania	Singapore
Bermuda	Luxembourg	Slovakia
British Virgin	Macao	Slovenia
Islands	Malta	Somaland
Brunei	Mayotte	South Korea
Bulgaria	Monaco	South
Canada	Montserrat	Ossetia
Cayman	Nagorno-	Spain
Islands	Karabakh	Svalbard
Chile	Nauru	Sweden
Christmas	Netherlands	Switzerland
Island	Netherlands	Taiwan
Cocos	Antilles	Tokelau
(Keeling)	New	Transnistria
Islands	Caledonia	Trinidad And
Cook Islands	New Zealand	Tobago
Costa Rica	Niue	Tristan Da
Croatia	Norfolk	Cunha
Cyprus	Island	Turks And
Czech	Northern	Caicos
Republic	Cyprus	Islands
Denmark	Northern	United Arab
Estonia	Mariana	Emirates
Falkland	Islands	United
Islands	Norway	Kingdom
Faroe Islands	Oman	Uruguay
Finland	Palau	Vatican
France	Palestine	Wallis And
French	Panama	Futuna
Polynesia	Pitcairn	Western
Germany	Islands	Sahara
Gibraltar	Poland	

TIER 5:

United States

PROFESSIONAL PROFILE

PROFESSIONAL/ACADEMIC DEGREE(S)

PROFESSIONAL TITLE

WORKPLACE SETTING

- ☐ ACADEMIC HEALTH CENTER ☐ INDUSTRY ☐ GOVERNMENT (VETERANS
ADMINISTRATION, NIH, NATIONAL
HEALTH SERVICE, ETC.)
- ☐ ACADEMIC DEPARTMENT ☐ GROUP PRACTICE
- ☐ HOSPITAL/HEALTH CENTER/CLINIC ☐ SOLO PRACTITIONER

PROFESSIONAL ROLES (PLEASE MARK **P** FOR PRIMARY AND **S** FOR SECONDARY)

- ☐ ADMINISTRATOR ☐ CLINICAL RESEARCHER ☐ POSTDOCTORAL RESEARCH
FELLOW
- ☐ ADVANCED PRACTICE PROVIDER
(CLINICAL PRACTITIONER WITHOUT
AN MD, DO, PHD, OR GLOBAL
EQUIVALENT) ☐ CLINICAL PRACTITIONER ☐ INTERN
- ☐ BASIC RESEARCHER ☐ EDUCATOR ☐ MEDICAL STUDENT
- ☐ CLINICAL FELLOW IN TRAINING ☐ RESIDENT
- ☐ GRADUATE STUDENT/PHD
STUDENT ☐ RETIRED

DEMOGRAPHIC INFORMATION

DATE OF BIRTH (MONTH/DAY/YEAR): ____/____/____

RACE (VOLUNTARY)

- ☐ AFRICAN AMERICAN/BLACK ☐ NATIVE AMERICAN/ESKIMO/ALEUT ☐ OTHER: _____
- ☐ PACIFIC ISLANDER ☐ HISPANIC
- ☐ ASIAN ☐ WHITE/CAUCASIAN

PRONOUNS (VOLUNTARY)

- ☐ SHE/HER/HERS ☐ ZE/HIR/HIRS ☐ PREFER NOT TO SAY
- ☐ HE/HIM/HIS ☐ NO PRONOUNS (ONLY REFER
TO ME BY NAME) ☐ OTHER: _____
- ☐ THEY/THEM/THEIRS

CERTIFICATION

BOARD CERTIFICATION

YEAR

SUBSPECIALTY CERTIFICATION

YEAR

ARE YOU ACCEPTING NEW PATIENTS AND WANT TO BE LISTED IN THE ENDOCRINE SOCIETY'S "FIND-AN-ENDOCRINOLOGIST"
DIRECTORY? ☐ YES ☐ NO

IN-TRAINING ASSOCIATE STATUS FOR FELLOW/STUDENT ASSOCIATES (REQUIRED FOR IN-TRAINING ASSOCIATE MEMBERSHIP RATE)

PROGRAM DIRECTOR AND/OR MENTOR INFORMATION

NAME AND TITLE

EMAIL ADDRESS

INSTITUTION AND DEPARTMENT/DIVISION

ANTICIPATED TRAINING COMPLETION DATE (MONTH/DAY/YEAR): ____/____/____ (REQUIRED)

IN WHICH TRAINING PROGRAM ARE YOU CURRENTLY ENROLLED?

- ☐ CLINICAL FELLOWSHIP ☐ GRADUATE SCHOOL ☐ UNDERGRADUATE SCHOOL
- ☐ POSTDOCTORAL/RESEARCH ☐ INTERNSHIP/RESIDENCY ☐ OTHER: _____
- ☐ FELLOWSHIP ☐ MEDICAL SCHOOL