



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

See reverse side for membership criteria.

TERM JANUARY 1, 2023–
DECEMBER 31, 2023

- \$349 FULL MEMBER
- \$179 EARLY CAREER MEMBER
- \$39 IN-TRAINING MEMBER
- \$239 ASSOCIATE MEMBER
- \$170 RETIRED MEMBER

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 (ONLINE ONLY)
 - \$109 RETIRED

THREE EASY WAYS TO JOIN

ONLINE AT
ENDOCRINE.ORG/JOIN

MAIL COMPLETED
FORM AND PAYMENT
IN ENCLOSED
ENVELOPE

FAX COMPLETED
FORM TO
[+1.202.736.9704](tel:+12027369704)

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.

- 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 MEMBER

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

ASSOCIATE MEMBER

Industry, research or healthcare professional without a doctoral degree

SUBMIT COMPLETED MEMBERSHIP APPLICATION AND PAYMENT:

ONLINE

endocrine.org/join

MAIL

Endocrine Society
P.O. Box 17020
Baltimore, MD 21298-9419

FAX

Completed form to
+1.202.736.9704

EMAIL

info@endocrine.org

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

PROFESSIONAL PROFILE

PROFESSIONAL/ACADEMIC DEGREE(S) _____ PROFESSIONAL TITLE _____

WORKPLACE SETTING

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

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

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

DEMOGRAPHIC INFORMATION

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

RACE (VOLUNTARY)

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

PRONOUNS (VOLUNTARY)

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

CERTIFICATION

BOARD CERTIFICATION _____ YEAR _____

SUBSPECIALTY CERTIFICATION _____ YEAR _____

ARE YOU ACCEPTING NEW PATIENTS AND WANT TO BE LISTED IN THE HORMONE HEALTH NETWORK'S "FIND-AN-ENDOCRINOLOGIST" DIRECTORY? YES NO

IN-TRAINING STATUS FOR FELLOW/STUDENT ASSOCIATES (REQUIRED FOR IN-TRAINING 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
- POSTDOCTORAL/RESEARCH FELLOWSHIP
- FELLOWSHIP
- GRADUATE SCHOOL
- INTERNSHIP/RESIDENCY
- MEDICAL SCHOOL
- UNDERGRADUATE SCHOOL
- OTHER: _____