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

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.

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

SOURCE CODE: __________________
## PROFESSIONAL PROFILE

<table>
<thead>
<tr>
<th>PROFESSIONAL/ACADEMIC DEGREE(S)</th>
<th>PROFESSIONAL TITLE</th>
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### 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)

<table>
<thead>
<tr>
<th>ADMINISTRATOR</th>
<th>CLINICAL RESEARCHER</th>
<th>POSTDOCTORAL RESEARCH FELLOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVANCED PRACTICE PROVIDER (CLINICAL PRACTITIONER WITHOUT AN MD, DO, PHD, OR GLOBAL EQUIVALENT)</td>
<td>CLINICAL PRACTITIONER</td>
<td>INTERN</td>
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<tr>
<td>BASIC RESEARCHER</td>
<td>CLINICAL FELLOW IN TRAINING</td>
<td>MEDICAL STUDENT</td>
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<td></td>
<td>GRADUATE STUDENT/PHD STUDENT</td>
<td>RESIDENT</td>
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<td></td>
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<td>RETIRED</td>
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### DEMOGRAPHIC INFORMATION

- DATE OF BIRTH (MONTH/DAY/YEAR): _____/_____/_______

### RACE (VOLUNTARY)

- [ ] African American/Black
- [ ] Native American/Eskimo/Aleut
- [ ] Other: ________________
- [ ] Hispanic
- [ ] White/Caucasian

### PRONOUNS (VOLUNTARY)

- [ ] She/Her/Hers
- [ ] He/Him/His
- [ ] They/Them/Their
- [ ] Ze/Hir/Hirs
- [ ] No Pronouns (Only refer to me by name)
- [ ] Prefer Not to Say
- [ ] Other: ________________

### CERTIFICATION

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<thead>
<tr>
<th>BOARD CERTIFICATION</th>
<th>YEAR</th>
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<th>SUBSPECIALTY CERTIFICATION</th>
<th>YEAR</th>
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**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**

<table>
<thead>
<tr>
<th>NAME AND TITLE</th>
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<th>EMAIL ADDRESS</th>
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**Institution and Department/Division**

<table>
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<tr>
<th>Anticipated Training Completion Date (Month/Day/Year): <em><strong><strong>/</strong></strong></em>/_______ (REQUIRED)</th>
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**In Which Training Program Are You Currently Enrolled?**

- [ ] Clinical Fellowship
- [ ] Postdoctoral/Research Fellowship
- [ ] Graduate School
- [ ] Internship/Residency
- [ ] Undergraduate School
- [ ] Medical School
- [ ] Other: ________________