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

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

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 JULY 1, 2022 – DECEMBER 31, 2023

☐ $419  FULL MEMBER

☐ $215  EARLY CAREER MEMBER

☐ $47  IN-TRAINING MEMBER

☐ $287  ASSOCIATE MEMBER

☐ $204  RETIRED MEMBER*

*REQUIRES RETIREMENT VERIFICATION

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:

☐ $131  WITHIN THE US

☐ $162  INTERNATIONAL

☐ $51  INTERNATIONAL EXPEDITED

☐ $24  IN-TRAINING (ONLINE ONLY)

I’d like to add a print subscription to JCEM:

☐ $191  WITHIN THE US

☐ $84  FULL INTERNATIONAL

☐ $270  INTERNATIONAL

☐ $122  INTERNATIONAL EXPEDITED

FREE  FULL AND RETIRED MEMBERS ONLY** REQUIRES RETIREMENT VERIFICATION

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: ____________
**PROFESSIONAL PROFILE**

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

**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  
- [ ] Clinical Researcher  
- [ ] Postdoctoral Research Fellow  
- [ ] Intern  
- [ ] Medical Student  
- [ ] Resident  
- [ ] Retired  
- [ ] Clinical Practitioner  
- [ ] Educator  
- [ ] Clinical Fellow in Training  
- [ ] Graduate Student/PhD Student  
- [ ] Clinical Fellow  
- [ ] 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  
- [ ] Native American/Eskimo/Aleut  
- [ ] Other: __________________

- [ ] Pacific Islander  
- [ ] Hispanic  
- [ ] White/Caucasian  

**PRONOUNS (VOLUNTARY)**

- [ ] She/Her/Hers  
- [ ] Ze/Hir/Hirs  
- [ ] Other: __________________

- [ ] He/Him/His  
- [ ] 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)**

- **Anticipated Training Completion Date (Month/Day/Year):** _____/_____/_______ (REQUIRED)

**IN WHICH TRAINING PROGRAM ARE YOU CURRENTLY ENROLLED?**

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