AMERICAN VEIN & LYMPHATIC SOCIETY

MEMBERSHIP APPLICATION

First: _____ MI: _____ Last: _____

Designation (MD, DO, RPhS, CLT-LANA, etc.): _____

Company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Mobile: _____ Email: _____

DEMOGRAPHIC INFORMATION

Primary Specialty: _____ Secondary Specialty: _____

Practice Type: _____ % of Venous Patients: _____ % of Lymphatic Patients: _____

Medical School: _____ Grad Year: _____

License #: _____ NPI #: _____ AMA #: _____

Residency Specialty: _____ Year Started in Phlebology: _____

Gender: ❑ Male ❑ Female Referral: ❑ Colleague ❑ Event ❑ Other_____

MEMBERSHIP OPTIONS

Member Dues

❑ Physician	$	550
❑ Allied Health	$	195
❑ International Allied	$	100
❑ International Physician	$	250
+Application Fee	$	95
- Coupon	$	_____

Coupon Code: _____

Total Dues $ _____

PAYMENT INFORMATION

❑ Check made payable to American Vein & Lymphatic Society ❑ Credit Card

Card Type ❑ MasterCard ❑ VISA ❑ American Express ❑ Discover

Name on Card: _____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____ Billing Zip Code: _____

Submit your application to membership@acpmail.org.

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www.veinandlymph.org • membership@myavls.org