

3RSCVPR

2009 MEMBERSHIP APPLICATION

Name _____ Degree/ Credentials _____

_____ New Application _____ Renewal

AACVPR Member Y / N AACVPR Fellow Y / N

Home Address Check Here to have correspondence sent to this address

Street _____

City _____

State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

Email _____

Employer Address Check Here to have correspondence sent to this address

Name of Employer _____

Street _____

State _____ ZIP _____

Phone(_____) _____ Ext

(_____) _____

Email _____

Fax (_____) _____

Title _____

Program Involvement

Cardiovascular Inpatient Outpatient Pulmonary Inpatient Outpatient

Membership Category

Registered Nurse Exercise Physiologist Respiratory

Therapist

Physician Physical Therapist Student

Other (specify) _____

Membership Fee \$25.00 (Students \$10.00 with copy of valid ID)

Membership valid January 1, 2009 through December 31, 2009

Mail completed Application to:

3RSCVPR
621 Mayville Avenue
Pittsburgh, PA 15226

Make checks payable to 3RSCVPR