



# TRAVEL, TEACH, LEARN & LEAD

## INTERNATIONAL SOCIETY FOR PROSTHETICS AND ORTHOTICS Membership Application

Mr.     Mrs.     Ms.     Dr.     Prof.     Other

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Present Post, Job or Position \_\_\_\_\_

Organization/Company/Institution \_\_\_\_\_

Telephone: \_\_\_\_\_ EMail \_\_\_\_\_

Web Address if applicable: \_\_\_\_\_

Professional Qualifications/Certifications \_\_\_\_\_

Date of Birth \_\_\_\_\_  Female     Male

### Professional Category

- |  |   |
|--|---|
| <input type="checkbox"/> Administrator           | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Engineer/Biomedical     | <input type="checkbox"/> Pedorthist             |
| <input type="checkbox"/> Medical Doctor          | <input type="checkbox"/> Podiatrist/Chiropodist |
| Subcategory if applicable                        | <input type="checkbox"/> Prosthetist/Orthotist  |
| <input type="checkbox"/> Orthopaedic Surgeon     | <input type="checkbox"/> Student                |
| <input type="checkbox"/> Pediatrician            | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Physiatrist             |   |
| <input type="checkbox"/> Rehabilitation Medicine |   |
| <input type="checkbox"/> Other _____             |   |

### Language Fluency

- |                                   |              |            |         |
|-----------------------------------|--------------|------------|---------|
| <input type="checkbox"/> English  | ___Excellent | ___Average | ___Poor |
| <input type="checkbox"/> French   | ___Excellent | ___Average | ___Poor |
| <input type="checkbox"/> German   | ___Excellent | ___Average | ___Poor |
| <input type="checkbox"/> Spanish  | ___Excellent | ___Average | ___Poor |
| <input type="checkbox"/> Japanese | ___Excellent | ___Average | ___Poor |
| <input type="checkbox"/> Other    | ___Excellent | ___Average | ___Poor |



Interest in Work?     Yes     No

Committee preference/interest

- |   |   |
|---|---|
| <input type="checkbox"/> International Outreach | <input type="checkbox"/> Membership                     |
| <input type="checkbox"/> Meetings/Conferencers  | <input type="checkbox"/> Communication/Public Awareness |
| <input type="checkbox"/> Education              |   |

Signed : \_\_\_\_\_ Date: \_\_\_\_\_

Please return to : US ISPO: PO Box 3188; Dublin OH 43016 or fax payment by credit card using the form on reverse side.

Thank you.

US Member Society - ISPO; PO Box 3188; Dublin, Ohio 43016 - Tel (614-659-0197) Fax (614) 336-8596



## INTERNATIONAL SOCIETY FOR PROSTHETICS AND ORTHOTICS APPLICATION FORM

### FULL MEMBER

\$195.00 USD

Professional member, or persons actively engaged in prosthetics, orthotics and rehabilitation engineering, including research, education, clinical practice and other significant aspects of prosthetics and/or orthotics. \$195.00

### SPONSORING MEMBER

\$520.00 USD

Persons and/or organizations actively involved in activities directly related to the objectives of ISPO and rendering financial support in excess of the regular membership fees. Sponsoring members are announced annually in the Journal and entitled to receive the ISPO Journal and to attend all conferences and scientific meetings of the Society and the World Assembly. When the sponsoring member is a company or group, one nominated delegate may enjoy all the privileges.

### STUDENT MEMBER

\$90.00 USD

Students or trainees in the disciplines as defined above under regular membership. Student application must be supported by documentary evidence from educational establishment or employer. Student membership is normally available for three years upon renewal for each year. *Must be accompanied by a letter confirming student status from applicant's school representative or employer of applicant.*

#### Method of Payment

- By check, payable to USISPO - USISPO; PO Box 3188; Dublin OH 43016
- By Credit Card
- Visa       Master Card       Am Express

Account Number \_\_\_\_\_

Exp. Date \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Amount to be Charged \_\_\_\_\_ Zip Code of Billing \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Fax (614) 336-8596

Email: dfarabi@columbus.rr.com

*Thank you in advance for your support of ISPO's important mission!*