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MEMBERSHIP / DONOR APPLICATION

CONTACT INFORMATION

Prefix (Ms., Dr., etc.): _____ Academic Degree(s) (M.D., Ph.D., etc.): _____

*Name:

First

M.I.

Last

*Address: _____

*City: _____ * State/ Prov.: _____ * Zip/ Postal Code: _____ Country: _____

*Phone: _____ Fax: _____ *Email: _____

*Occupation: _____ Dept.: _____ Organization: _____

Specialty: _____ Please Indicate Interest: ___ Research ___ Clinical ___ Both ___ Other

* Required fields

Please exclude my name from the online membership directory of IACFS members that is available only to other members at www.IACFS.net

For Membership in the IACFS

(check all that apply for your category)

One year Memberships include IACFS newsletter, reduced conference registration fees, discounted IACFS materials, unlimited website access and website listing.

New Member

Renewing Member

For Full Member, voting (Professionals including Researchers, Clinicians, Therapists):

1 Year Professional—\$100 2 Year Professional—\$150 Lifetime Professional—\$1,000

For Associate Member, non-voting (Students, Patients, Other Interested Individuals)

1 Year Associate—\$40 2 Year Associate—\$60

For Supporting Member, non-voting (Institutional, Corporate, Support Group, and Individual Sponsors):

Standard \$200 Bronze \$500 Silver \$1,000 Gold \$2,500 Platinum \$5,000

For Donations to the IACFS

I wish to donate to the IACFS

To the Rudy Perpich Memorial Fund (International Conference Speakers): \$ _____

To the Junior Investigator Award \$ _____

To the IACFS General Fund \$ _____

Donation in the name or honor of: _____

Total amount remitted: \$ _____

Check: Please make check or money order payable in US funds to IACFS and mail to the address above.

VISA Mastercard American Express: Please mail to address above or fax to 847-579-0975

Card Number: _____ Exp. Date: _____

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