



FELLOWSHIP APPLICATION

Instrumental to Patient Care®

Incomplete applications will be returned. Complete all sections exactly to avoid disappointment. Please type or clearly print all information.

Section One – Applicant Information

Name: _____ IAHCSMM Membership Number: _____
First and Last Name, Middle Initial

Home Address: _____
Street Address City State Zip

Home Telephone Number: _____ E-mail: _____

Affiliated Hospital or Institution: _____
Full Name of Hospital or Institution

Hospital/Institution Address: _____
Street Address City State Zip

Hospital/Institution Phone Number: _____ Fax Number: _____

Current Title/Position in Hospital: _____ Number of years experience in CS: _____

Section Two – Payment Information

Fellowship Processing Fee is \$50.00

You must include the fee of \$50.00 with this application, in the form of: Personal Check, Money Order, Bank Draft, or Credit Card.
(Note: IAHCSMM does not accept purchase orders of any kind)

- My check, money order or bank draft is enclosed, and made payable to: IAHCSMM
- My credit card is to be charged, and I have supplied ALL necessary information below: Visa MasterCard American Express Discover

Name: _____
Please print name as it appears on credit card

_____ Credit Card Account Number _____ Expiration _____ CVV2 Number (3-4 digit security code)

_____ Signature

**Return applications with payment to: IAHCSMM, 213 West Institute Place, Suite 307, Chicago, IL 60610
Or Fax to: 312-440-9474 Attn: Fellowship**

Section Three – Proposed Topic

Proposed Topic Title: _____
(Please attach a detailed outline of your topic, referencing the Fellowship Brochure for guidance on construct)

FOR OFFICE USE ONLY

Date Application Received: _____ Mentor Assigned: _____
Date Application Sent to Committee: _____ Date Fellowship Accepted: _____