



## New or Renewal SCACM MEMBERSHIP FORM

### **STEP 1: Select ONE Application Type:**

### **STEP 2: Select ONE Membership Level:**

### **STEP 3: Provide Contact Information:**

First Name: Last Name:  
Degree/Certification: Email:  
Phone:  
Hospital/Organization:  
Department:  
Street:  
City:  
State:  
Zip code:  
Country/Province:      United States      Other (specify):

### **STEP 4: Select Payment Type:**

I will mail a **CHECK**, payable to: SCACM Membership, to SCACM Treasurer (See "**Mail to**" below)  
I will pay by **CREDIT CARD** by providing my card information (See "**Phone our Office**" below)

### **STEP 5: Submit your Completed Membership Form and/or Payment or Contact Us for assistance**

- Email [scacm@scacm.org](mailto:scacm@scacm.org)
- Secure Fax: (877) 222-8812
- Phone our Office: (877) 902-3030
- Mail to: SCACM Treasurer  
6725 W. Central Ave, Suite M 309  
Toledo, OH 43617
- NOTE: We will send you a confirmation email when we have processed your form.