NATIONAL LIPID ASSOCIATION

National Lipid Association
6816 Southpoint Pky., Ste. 1000
Jacksonville, Florida 32216
904.998.0854 Fax 904.998.0855

APPLICATION FOR MEMBERSHIP

Name_____ Degree(s)_____
Date of Birth (mm/dd/yy) _____ ☐ Male ☐ Female
Job Title(s): _____

TYPE OF MEMBERSHIP

(Please read membership criteria)

☐ **Regular** ☐ **$195 or** ☐ **$510/3 years**
Appropriately credentialed health professional in the US or Canada; engaged in the treatment of patients with lipid disorders or involved in research or educational activities relating to lipid disorders.

☐ **Industry** ☐ **$195 or** ☐ **$510/3 years**
Health professional or other representative of the medical industry as an employee or contractor, given that you do not promote or participate in activity directly related to sales or marketing of products or services.

☐ **International** ☐ **$195 or** ☐ **$510/3 years**
All applicants otherwise eligible under Regular or Industry criteria but residing outside the US or Canada. International members receive membership benefits, including publications, electronically.

☐ **Fellow/Trainee–Complimentary**
(Anticipated year of completion: _____)
Individuals actively enrolled in a graduate or postgraduate training program for the treatment or investigation of lipid disorders and in pursuit of full credentialing in their specialized area of medical study. A letter from your program director or school registrar stating date of completion must accompany the application.

PRACTICE INFORMATION

☐ Hospital ☐ Private Practice ☐ Group Practice ☐ Lipid Clinic ☐ Pharmacy
☐ Other (specify): _____

MAILING PREFERENCE

☐ Office ☐ Home

CONTACT INFORMATION

Email address *(mandatory)*: _____
Primary Office/Employer/Company *(mandatory)*: _____
Primary Office Address *(available in public member searches)*: _____
City:_____ State/Province:_____ ZIP:_____ Country:_____
Phone:_____ Fax:_____
Practice/Institution/Professional Website:_____

Home Address *(kept private)*: _____
City:_____ State/Province:_____ ZIP:_____ Country:_____
Phone:_____ Mobile:_____

☐ Office Manager/ ☐Assistant: Name _____ Phone/Email:_____

NLA Correspondence Preferences: Unsubscribe from ☐ Blast Email ☐ Blast Fax

EDUCATION HISTORY *(Please complete as applicable):*

College/University:_____ Degree:_____ Year Obtained:____
Graduate University:_____ Degree:_____ Year Obtained:____
Medical School:_____ Degree:_____ Year Obtained:____
Internship/Residency:_____ Program:_____ Year Completed:____
Fellowship/Postgrad:_____ Program:_____ Year Completed:____
Present Medical School/Hospital Affiliation/Appointments:

_____

_____

BOARD CERTIFICATIONS

Board:_____ Year Certified:____ Most recent:_____
Board:_____ Year Certified:____ Most recent:_____
Board:_____ Year Certified:____ Most recent:_____
Board:_____ Year Certified:____ Most recent:_____

Please briefly explain how you are involved in treatment, research, or education in the field of lipid disorders *(mandatory)*: _____

_____

_____

_____

_____

_____

_____

_____

Are you interested in pursuing certification in the field of Lipidology?
☐ *Yes* ☐ *No* ☐ *Unsure*

How did you learn about the NLA?
☐ *Colleague (Name:_____)* ☐ *Website* ☐ *Mail/Brochure* ☐ *Print Ad*
☐ *Convention/Meeting (Name:_____)* ☐ *Other:*_____

Payment info: Check #_____ ☐ Visa ☐ MasterCard ☐ AmEx
Name on Card _____ Card Number_____ Exp.____

Signature _____

☐ Please renew my membership automatically each December (credit card only).

Tracking Code _____