

**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**  \$150 or  \$375/3 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**  \$150 or  \$375/3 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**  \$150 or  \$375/3 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: \_\_\_\_\_

**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** (Please attach a copy of certificate from each board claimed):

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 \_\_\_\_\_