



Membership Application

Visit www.ISCD.org for a complete description of membership categories. Membership is valid January – December and dues are not prorated.

Check ONE Appropriate Category

	US	International
<input type="checkbox"/> Clinician, Scientist/Researcher	\$300*	\$220
<input type="checkbox"/> Technologist – Regular	\$85*	\$65
<input type="checkbox"/> Technologist – Upgraded – w/ JCD Online Access	\$115*	\$95
<input type="checkbox"/> Technologist – Full – w/ JCD Online Access & JCD Print Subscription	\$130*	\$110
<input type="checkbox"/> Associate** – Regular	\$65	\$65
<input type="checkbox"/> Associate** – Upgraded – w/ JCD Online Access	\$95	\$95
<input type="checkbox"/> Associate** – Full – w/ JCD Online Access & JCD Print Subscription	\$110	\$110
<input type="checkbox"/> Retired – Regular	\$65	\$65
<input type="checkbox"/> Retired – Upgraded – w/ JCD Online Access	\$95	\$95
<input type="checkbox"/> Retired – Full – w/ JCD Online Access & JCD Print Subscription	\$110	\$110
<input type="checkbox"/> Industry Member	\$220	\$220
<input type="checkbox"/> Corporate – Contact ISCD for information at (860) 259-1021		

(PLEASE PRINT OR TYPE)

Dr. Mr. Ms. Other: _____

First/Given Name: _____ (M.I.) _____ Last/Family Name: _____

Degree: _____ Position: _____

Area of Specialty (Rheum., Endo., etc): _____

***If applying for Associate Membership, Residency/Fellowship end date (MO/YR): _____*

Business Address

Primary Address

Institution/Firm: _____

Business Address: _____

City: _____ State/Province: _____ Country: _____

Zip/Postal Code: _____ E-mail: _____

Business Phone #: _____ Business Fax #: _____

Home Address Primary Address

Street Address: _____

City: _____ State/Province: _____ Country: _____

Zip/Postal Code: _____ E-mail: _____

Home Phone #: _____ Home Fax #: _____

How did you hear about ISCD? _____ Referred by: _____

DXA Machine Used Hologic GE Lunar Norland Peripheral Unit Other _____Are you a member of the American Medical Association? Yes NoHow do you bill for Medicare? Non-Facility/Office-based Facility/Hospital-based
 Not Applicable Unsure**FORM OF PAYMENT**Check a form of payment: Check (must be in US Dollars and drawn on a bank located in the US)

Name as it appears on Credit Card: _____

Signature: _____

 VISA MasterCard AMEX Wire Transfer, Please contact ISCD for bank details

Credit Card Number: _____ Expiration Date: _____

Card Verification Value code (CVV): _____

(MasterCard & Visa: 3 digit code listed on the back of card; American Express: 4 digit code listed on the front of the card)

Send your completed application and payment to:

International Society for Clinical Densitometry, 306 Industrial Park Road, Ste 208, Middletown, CT 06457Phone 860.259.1000 – Fax 860.259.1030 – E-mail: iscd@iscd.org - website: www.ISCD.org**Fax credit card information to: 860.259.1030**