**Group Member Discount Program**

**Institution / Department Information**

|  |  |
| --- | --- |
| Institution name |  |
| Department name |  |
| Street address |  |
| City, State, Zip |  |

**Primary Contact Information**

|  |  |
| --- | --- |
| Name |  |
| Phone number |  |
| Email address |  |

**Regular Member Dues - $385.00**

*ASRA Pain Medicine does not participate in lobbying or political donations; no portion of member dues is used for those activities.*

|  |  |  |  |
| --- | --- | --- | --- |
| Regular members are defined as physicians who reside and/or work full time in the US, Canada, and Europe. | Number of Regular Members | Group Member Discount Program Dues | Total Amount Due |
|  | **$385.00 each member** | $ |

**Payment Options**

1. Payment enclosed:

Check made payable to ASRA Pain Medicine.

Credit card

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name as it appears on the card | |  | | | | |
| Billing address of card | |  | | | | |
| Card number |  | | Expiration |  | Security code |  |

2. Invoice us at the name and address above.

Customer approval signature: \_\_\_\_\_\_\_\_\_\_\_ Date:

**Submit the following to the address below:**

* This completed and signed invoice with payment.
* The updated list of your current/new physician members (email address required)