

**AMERICAN CLINICAL  
MAGNETOENCEPHALOGRAPHY SOCIETY  
APPLICATION FOR MEMBERSHIP**

Please print, fill out, and send to: ACMEGS, Inc.  
c/o Roland Lee, Secretary  
Dept. of Radiology, UCSD and VA San Diego  
3350 La Jolla Village Drive, MC 114  
San Diego, CA 92161

Name (First Last): \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
ZIP Code \_\_\_\_\_ Phone: \_\_\_\_\_

Degree(s) \_\_\_\_\_ Date(s) Received \_\_\_\_\_ Degree Pursuing\* \_\_\_\_\_ Date Expected \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Business Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Department \_\_\_\_\_  
Institution \_\_\_\_\_  
Institution Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP \_\_\_\_\_  
Country \_\_\_\_\_

Check Desired Class of Membership:

- Full Member (M.D. or Ph.D. required)**  
 **Associate Member (Technologists, Students, or Other Clinicians in an Affiliated Discipline) Please Specify: \_\_\_\_\_**

PLEASE (1) ATTACH A 2 PAGE CV; (2) HAVE THIS SIGNED BY TWO FULL MEMBERS OF THE SOCIETY WHO SHOULD SIGN AND DATE THIS APPLICATION FORM; (3) ATTACH A CHECK FOR \$50.00 FIRST YEAR MEMBERSHIP DUES

1. SPONSOR'S NAME (PRINT OR TYPE) \_\_\_\_\_  
SPONSOR'S SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_

2. SPONSOR'S NAME (PRINT OR TYPE) \_\_\_\_\_  
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DATE \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_