



# MEMBERSHIP APPLICATION

Date: \_\_\_\_\_

## American Society for Neural Therapy and Repair

Membership in the Society is open to persons who have demonstrated a commitment to promoting and encouraging education and research with respect to Neural Transplantation and/or Repair. For more information, call (813) 974-3154 or Fax (813) 974-3078 or e-mail [dcmorrison@usf.edu](mailto:dcmorrison@usf.edu). There are currently four categories of membership:

- **Fellows** shall be chosen from members who have made substantial contributions to the field of neural transplantation and have been members **for at least three years**.
- **Regular Members** shall be limited to scientists who are actively engaged in research or practice of neural transplantation as documented by a significant number of publications in referred journals.
- **Associate Members** shall be students with at least one year minimum of graduate work and strong letters of support from faculty familiar with their research, stating that the applicant has demonstrated a commitment to Neural Transplantation and/or Repair as documented by several publications and/or meeting presentations.

A. Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Email: \_\_\_\_\_ Fax No: \_\_\_\_\_

Professional Address: \_\_\_\_\_

\_\_\_\_\_

Highest Degree Earned: \_\_\_\_\_ Discipline: \_\_\_\_\_

Institution: \_\_\_\_\_

### B. MEMBERSHIP CATEGORY DESIRED:

- Fellow*
- Regular Member*
- Associate Member (Student - Enclose Letters)*

### C. PLEASE ENCLOSE A COPY OF YOUR CURRICULUM VITAE OR NIH BIOSKETCH (*in English*).

D. **ANNUAL DUES** for the ASNTR are (U.S. Dollars) \$100 for Fellows; \$60 for Regular; and \$20 for Associate (Student) Members. Please make checks payable to "ASNTR." (*ASNTR Federal Employee ID Number: EIN62-1576262*)

### PAYMENT BY CREDIT CARD:

Credit Card Number: \_\_\_\_\_

Check One: (*NO other cards accepted.*)  **VISA**  **MASTER CARD** Amount: \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

**PAYMENT BY CHECK:** Amount Enclosed: \$ \_\_\_\_\_ Check No.: \_\_\_\_\_ Date: \_\_\_\_\_

E. Mail completed application and vitae to:

Donna C. Morrison  
Dept of Neurosurgery MDC-78  
Center for Aging and Brain Repair  
University of South Florida  
12901 Bruce B Downs Blvd  
Tampa FL 33612-4799