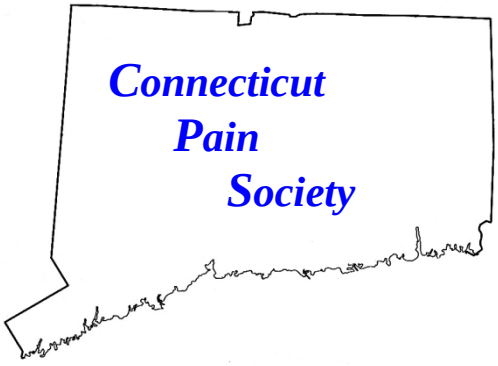

Rahul Anand, MD
President

CONNECTICUT PAIN SOCIETY
MEMBERSHIP APPLICATION

Name: _____

Address: _____

_____

Phone: (_____)-_____-_____ Fax: (_____)-_____-_____

E-mail address: _____

Personal Data: Date of Birth _____/_____/_____ Gender ___M ___F

Medical Degree: _____MD ____DO _____RN _____PA _____Other

Specialty: _____

Board Certified: _____ ABA _____ABPMR _____Other

Pain Mgmt. ____Y____N If yes, which cert._____

Percentage of practice dedicated to Pain Management:_____%

Do you perform spinal injection therapy? : _____yes _____no

ASIPP member: _____yes _____no _____pending

Please list two professional references: _____

_____

I hereby apply for application as: Annual Dues

_____ Active Member: $150
Must be a Physician specializing in Pain Management, perform interventional treatments (injections or surgery at least 50% of practice), ***and*** an Active (i.e., paid) Member of ASIPP.

_____ Associate Member $75
Open to Non-ASIPP members, non- interventionalists, Non-Pain Management Physician, Nurse, PA, NP, Administrators, Pharmacists, Physical Therapists and Psychologists, etc.

Please include check with application. Payable to: Connecticut Pain Society

Signature of Applicant: _____ Date: _____

Send to: CPS c/o CSMS, 127 Washington Ave, E Bldg, Lower Level, North Haven, CT 06473