

Society for Clinical Trials, Inc.

Membership Application

New Member Application Membership Renewal

1. Please print or type the following information: (mailing information will be forwarded to publisher)

Name: _____

Organization: _____

Address: _____

City, State: _____ Postal Code: _____ Country: _____

Business Telephone: _____ FAX: _____

E-mail Address: _____

Please note: all students need to send in proof of their status before they can become a student member. Acceptable forms of student verification include copy of student ID, letter from your school, or your class list. Please fax this to SCT at 215/963-9785.

Type of Membership: Full (\$120.00) Student (\$50.00)

2. Would you like to support the Society by making a donation? We encourage members to consider making a tax deductible gift to support the non-profit activities sponsored by the Society.

Please be generous! The Society makes an effort to keep dues reasonable for our members. Your generous donations will help to fund our valuable educational and outreach programs that benefit the clinical trials community.

Please see the options below. You are encouraged to sponsor a member through the Mary Karpers-Burke scholarship fund, or contribute to one of the five other donation options.

Mary Karpers-Burke Member Sponsorship

This support involves sponsoring one year of membership for a new member, in honor of Mary Burke, who served the Society as Coordinator for over 20 years.

Name of New Member:

First: _____ M.I.: _____ Last: _____

E-mail of new member _____

Type of Membership: Full (\$120.00) Student (\$50.00)

General Fund: This fund allows the Society to use your gift flexibly to support various important activities.

\$50 \$100 \$500 \$ Other _____

Sylvan Green Scholarship Program: This program provides funds for a physician clinical trialist to attend our annual meeting and present a paper.

\$50 \$100 \$500 \$ Other _____

Curtis Meinert Honorary Keynote Address: This fund supports the travel and honorarium for a prominent keynote speaker.

\$50 \$100 \$500 \$ Other _____

Thomas Chalmers Student Scholarship Award: This fund supports travel to the meeting for students who submit the most meritorious abstracts.

\$50 \$100 \$500 \$ Other _____

Most Advanced Degree

- MD/DO
 DDS/DMD/BDS
 Ph.D/ScD/Dr.PH
 MA/MS/MSc
 RN/BSN
 MBA
 MPH/MSPH
 BA/BS
 Other: _____

Male Female

Year of Birth _____

Mailing Address for Journal if different from Business Address:

Street: _____

City, State: _____

Postal Code: _____

Country: _____

3. Payment

Total dues: \$ _____

Total donations: \$ _____

Total payment: \$ _____

Method of Payment

(Visa, MasterCard or check ONLY)

Check (U.S. Dollars drawn on a U.S. Bank).

Federal Tax ID number: 52-115-1889

Check must be made **payable to**
Society for Clinical Trials, Inc.

Credit Card

MasterCard Visa

Card #: _____

Exp. _____

Name on Card: _____

Address on Card: _____

Zip Code: _____

Signature: _____

I give permission for my E-Mail Address and Telephone Number to be published on the SCT Web Page.

Yes No

I give permission for my mailing address to be included in the SCT Mailing List available for rent.

Yes No

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The following information will facilitate chairperson/committee selection and planning of meetings that will best serve members' interests and needs.

2. Please check the one primary box that best represents your primary institutional affiliation.

- | | |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> University | <input type="checkbox"/> Industry (if selected, check one box below) |
| <input type="checkbox"/> Contract Research Organization | <input type="checkbox"/> Biotechnology <input type="checkbox"/> Medical Devices |
| <input type="checkbox"/> Government (if selected, check one box below) | <input type="checkbox"/> Pharmaceutical <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> FDA <input type="checkbox"/> NIH <input type="checkbox"/> VA | <input type="checkbox"/> Self-employed |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other, specify: _____ |

3. Please check all that represent your job description.

- | | | |
|------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Biostatistician/Statistician | <input type="checkbox"/> Clinical Coordinator |
| <input type="checkbox"/> Clinical Research Associate | <input type="checkbox"/> Data Manager | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Epidemiologist | <input type="checkbox"/> Health Economist | <input type="checkbox"/> Medical Doctor (Physician) |
| <input type="checkbox"/> Medical Ethicist | <input type="checkbox"/> Principal Investigator | <input type="checkbox"/> Programmer/Systems Analyst |
| <input type="checkbox"/> Project Officer | <input type="checkbox"/> Research Nurse | <input type="checkbox"/> Student |
| <input type="checkbox"/> Other: (Please Print) _____ | | |

4. Medical areas of interest: Please check all that apply.

- | | | |
|--------------------------------------------------------|----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Gerontology | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gynecology/Obstetrics | <input type="checkbox"/> Oral Diseases |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Kidney/Urologic Disorders | <input type="checkbox"/> Pulmonary Diseases |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neonatology | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Visual Disorders |
| <input type="checkbox"/> Endocrine/Metabolic Disorders | | |
| <input type="checkbox"/> Others: (Please Print) _____ | | |

5. Methodological/Operational areas of primary interest: Please check all that apply.

- | | | |
|----------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Clinical Evaluation | <input type="checkbox"/> Health Economics/Cost Utilization | <input type="checkbox"/> Patient Compliance |
| <input type="checkbox"/> Coordination of Clinical Trials | <input type="checkbox"/> Interpretation of Med. Documents | <input type="checkbox"/> Quality Assurance |
| <input type="checkbox"/> Data Analysis and/or Monitoring | <input type="checkbox"/> Laboratory Methodology | <input type="checkbox"/> Quality of Life |
| <input type="checkbox"/> Data Systems Design/Informatics | <input type="checkbox"/> Medical Ethics | <input type="checkbox"/> Statistics/Methodology |
| <input type="checkbox"/> Epidemiology | <input type="checkbox"/> Medical Informatics | <input type="checkbox"/> Trial Design |
| <input type="checkbox"/> Other: (Please Print) _____ | | |

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6. Committees on which you are willing to serve: Please check all that apply.

Education

Membership

Nominating

Program

Web Oversight

7. For new members only, how did you learn about the Society for Clinical Trials (please check all that apply):

Colleague

SCT website

Clinical Trials Journal

SCT brochure

SCT mailing or e-mail

SCT presence at another meeting

SCT educational program

Annual meeting announcement

Other: *(Please Print)* _____

As a member of the Society for Clinical Trials, Inc., you will receive an annual subscription to the journal *Clinical Trials: Journal of the Society for Clinical Trials* published bi-monthly. Should the journal not be received within two (2) months of application and payment, contact the Business Office immediately at the telephone number listed below.

Please mail to the Society for Clinical Trials, Inc. 100 North 20th Street, 4th Floor

Philadelphia, Pennsylvania 19103 – Telephone: +1-215-564-3484; Fax Number +1-215-963-9785

E-Mail: SCT@FERNLEY.COM

Office Use Only

Received

Date: _____ Payment: _____

Year: _____ Check #: _____

Journal Sub. #: _____