



This form is for those paying with a check. Please print the form and mail the completed copy (keeping a copy for your records) along with your remittance. You will be notified upon acceptance of your application.

\*What is your E-mail address? \_\_\_\_\_

Enter your contact information below:

Name: \_\_\_\_\_ IH Designation: \_\_\_\_\_
(CIH,CSP, etc. - Please limit to your primary)

My contact and other information remains the same.

IF REQUIRED, please make any changes in the form fields below (do not check above).

Title: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_ Work Home

Address 2: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Home Fax Number: \_\_\_\_\_

Additional Information:

Membership Level (Select One):

- Full Membership - \$25 Associate Membership - \$25
Student Membership - \$5 Organizational Membership - \$50
Honorary (send form, dues are waived) Life (send form, dues are waived)

The following information is optional - select only if changes have occurred:

Which of the following certifications do you hold? (check all that apply)

- CIH CSP CHMM
IHT OHST PE

Other: (please list - do not include 40 hr. training classes) \_\_\_\_\_

Which related organizations are you a member of?

- WMIHS ASSE SOT OPA (DRS)
ACGIH APCA APHA AOHN (NURSES)

Other: (please list) \_\_\_\_\_

Which of the following committees do you have an interest in?

- Awards International Newsletter
Community Outreach Legislative Nominating
Continuing Education Membership Publicity
Program and Arrangements