



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)