Association of Dermatology Administrators & Managers

Membership Application

Take advantage of the special practice discount!

Personal Information (Please print clearly)

Prefix/Suffix: ❑ Ms. ❑ Mrs. ❑ Mr. ❑ MD ❑ DO ❑ RN ❑ LPN ❑ Other _____

Name (First, MI, Last)

Employer (Practice or University Name)

Address | Suite

City | State / Region | Postal Code | Country

Office Phone | Office Fax

Email | Mobile

Would you like a mentor for your first year of membership? ❑ Yes ❑ No

Professional Information

Are you employed…?
❑ Full Time
❑ Part Time
❑ Presently Unemployed
❑ Other (describe) _____

What is your position/title?
❑ Administrator
❑ Nurse/Medical Assistant
❑ Office Manager
❑ Accountant/Bookkeeper
❑ Physician
❑ Billing Specialist/Coder
❑ Other _____

Which best describes your clinic?
❑ Solo Practice
❑ Single-specialty
❑ Multi-specialty
❑ Academic

What best describes your practice?
❑ Solo practitioner
❑ 2-5 physician
❑ 5+ physicians

What % of your practice is…?
❑ ____**%** General Dermatology
❑ ____**%** Cosmetic
❑ ____**%** MOHS / Skin Cancer
❑ ____**%** Dermatology Pathology Lab

Does your office have physician extenders?
❑ Yes; How many? _____
❑ No

How did you hear about ADAM?
❑ ADAM Member (provide name) _____
❑ Friend/Colleague
❑ ADAM Meeting
❑ Society/Chapter Meeting
❑ ADAM Website
❑ Direct Mail
❑ Other _____

Payment Information (U.S. dollars only)

$325 Individual Membership (expires Dec. 31)	**$**
$275 Practice - Additional Members (with 3 or more new members from same practice; expires Dec. 31)	**$**
Total	**$**

❑ Check enclosed (made payable to ADAM)

❑ Charge my: ❑ VISA ❑ MasterCard ❑ American Express

Card Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Exp. (MM/YY): |__|__/__|__|

Billing Address ZIP Code |___|___|___|___|___|

Cardholder's Name: _____

Authorized Signature: _____

Submit application(s) to:
5550 Meadowbrook Drive, Suite 210, Rolling Meadows, IL 60008-3805
P: 866.480.3573 | F: 800.671.3763 | E: adaminfo@samiworks.net | W: www.ada-m.org