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**SCDM Organizational Membership Application**

**Section A: Company Information**

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

Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip/Postal Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip/Postal Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B: Member Company Information**

**Employer Type:**

❑ Academic Health Center

❑ Biotechnology

❑ Centralized Laboratory

❑ Consulting Firm

❑ Contract Research Organization (CRO)

❑ Hospital

❑ Medical Device/Diagnostic/Imaging

❑ Other

❑ Pharmaceutical

❑ Recruiter

❑ Regulatory Agency

❑ Site Management

❑ Vendor

**Section C: Membership Type**

❑ High Income County $125 per unit. Number of units required: **\_\_\_\_\_\_\_\_**

❑ Middle Income Country $80 per unit. Number of units required: **\_\_\_\_\_\_\_\_**

❑ Lower Income Country $40 per unit. Number of units required: **\_\_\_\_\_\_\_\_**

**Section D: Payment Information**

**TOTAL AMOUNT DUE $\_\_\_\_\_\_\_\_**

❑ Check Enclosed

Please make all checks payable to SCDM. Please do not send cash.

❑ Visa ❑ MasterCard ❑ American Express

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date (month/year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Wire Transfer (Please do not forget to mention the invoice number)

Bank Name: ING Belgium

Bank Account holders name: SCDM

IBAN Code: BE78310177451886

BIC: BBRUBEBB100

Bank account holder’s address: Boulevard du Souverain 230, 1160 Brussels, Belgium

**Please fill in the names of all delegates:**

|  |  |  |
| --- | --- | --- |
| **Full Name** | **Email address** | **County** |
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If more than, please use a separate sheet!

One person from the company will be appointed as the ***Group Contact*** for administrative purposes. **The Group Contact may or may not be a delegate**.

**Return to:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Americas** | **India** | **Global Headquarters** | **China** |
| **Society for Clinical Data Management**7918 Jones Branch DriveSuite 300McLean, VA 22102Tel: 703-651-8188Fax: 703-506-3266info-am@scdm.org  | **Society for Clinical Data Management**203, Wing B, Citipoint(Near Hotel Kohinoor Continental)J. B. Nagar, Andheri-Kurla RoadAndheri (East). Mumbai – 400059 Tel:  +91 22 61432600 Fax: +91 22 67101187info-in@scdm.org  | **Society for Clinical Data Management**Boulevard du Souverain, 280B-1160 Brussels, BelgiumTel:  +32-2-320 2529info@scdm.org  | **Society for Clinical Data Management**Level 4 Puxi Management CenterNo.801 Jumen RoadShanghai 200023ChinaPhone: +86-21-2312 3523Fax: +86-21-2312 3699info-cn@scdm.org  |

[www.scdm.org](http://www.scdm.org)