



Society for Clinical Data Management
DATA DRIVEN

SCDM Student Membership Application

Section A: Member Contact Information

Name: _____

Title: _____

Date of Birth: _____

Company or Institution: _____

Business Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Country: _____ Tel: (_____) _____ Fax: (_____) _____

Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Country: _____ Tel: (_____) _____ Fax: (_____) _____

Primary E-mail: _____ Secondary E-mail: _____

Section B: Member Company Information

Employer Type:

Academic Health Center

Other

Biotechnology

Pharmaceutical

Centralized Laboratory

Recruiter

Consulting Firm

Regulatory Agency

Contract Research Organization (CRO)

Site Management

Hospital

Vendor

Medical Device/Diagnostic/Imaging

Position Type:

- Executive Management
- Senior Management
(reports to Exec Mgmt)
- Middle Management
(reports to Sr. Mgmt)
- Administrative Staff
(reports to Mid. Mgmt)
- Student
- Not Currently Employed
- Other: _____

Section C: Membership Type

- Student Member- High Income Country \$50.00 *(Enclose proof of student status)*
- Student Member- Middle Income Country \$40.00 *(Enclose proof of student status)*
- Student Member- Low Income & Lower Middle Income \$30.00 *(Enclose proof of student status)*

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 _____

Return to:

Americas	India	Global Headquarters
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