



Society for Imaging Informatics in Medicine Institutional Membership Application

Institution Information:

Institution Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Country: _____

Website: _____

Primary Contact:

The Primary Contact is responsible for membership payments and managing the sponsored members. To receive SIIM membership benefits, they must also be a sponsored member (listed on the next page).

Salutation: ☐ Dr. ☐ Mr. ☐ Ms.

First Name: _____

Middle Name: _____

Last Name: _____

Degree: _____ ☐ Male ☐ Female

Title: _____

Department: _____

Phone: _____

Email: _____

☐ Address same as Institution; Or

Address: _____

City/State/Zip: _____

Country: _____

SIIM Membership Category

(Indicate selection below)

- ☐ **Level 1 Institutional Membership**
\$896.00 annually
Includes 4 sponsored individual memberships.
- ☐ **Level 2 Institutional Membership**
\$1,465.00 annually
Includes 8 sponsored individual memberships.
- ☐ **Level 3 Institutional Membership**
\$2093.00 annually
Includes 12 sponsored individual memberships.
- ☐ **Level 4 Institutional Membership**
\$2850.00 annually
Includes 16 sponsored individual memberships.

* Additional sponsored individual memberships can be added to Institutional Membership at the cost of \$170/person annually.

Institution Profile

Occupational Setting (select one category – best match):

- ☐ Community Hospital
☐ Government (non-hospital)
☐ Military/VA/Govt Hospital
☐ University/College (non-hospital)
☐ University Hospital
☐ Imaging Center/Office/Clinic
☐ Other _____

Submission & Payment Information

You can pay for your SIIM membership with check or credit card.

To pay with check, please mail your completed application form with payment to:

SIIM Membership
19440 Golf Vista Plaza, Suite 330
Leesburg, VA 20176-8264

To pay with credit card, please send your completed application to SIIM by email or fax:

Email: info@siim.org
Fax: 703-723-0415

We will prepare a membership invoice and email it to you with instructions on how to pay by credit card online.

Sponsored Member Listing

Please enter your sponsored member information on the following pages, filling in the appropriate number for your Institutional Membership Category. Alternatively, you can send a list of names and emails for the sponsored members and they will be emailed a link to complete their own member profile.



Society for Imaging Informatics in Medicine

Institutional Membership Application

Sponsored Member #1

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Sponsored Member #2

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	



Society for Imaging Informatics in Medicine Institutional Membership Application

Sponsored Member #3

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Sponsored Member #4

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	



Society for Imaging Informatics in Medicine

Institutional Membership Application

Sponsored Member #5

(Institutional Level 2 and 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Sponsored Member #6

(Institutional Level 2 and 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	



Society for Imaging Informatics in Medicine

Institutional Membership Application

Sponsored Member #7

(Institutional Level 2 and 3 Only)

Sponsored Member #8

(Institutional Level 2 and 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	



Society for Imaging Informatics in Medicine

Institutional Membership Application

Sponsored Member #9 (Institutional Level 3 Only)

Sponsored Member #10 (Institutional Level 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	



Society for Imaging Informatics in Medicine

Institutional Membership Application

Sponsored Member #11 (Institutional Level 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	

Sponsored Member #12 (Institutional Level 3 Only)

Salutation:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
First Name:			
Middle Name:			
Last Name:			
Degree:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title:			
Department:			
<input type="checkbox"/> Address same as Institution; Or			
Address:			
City/State/Zip:			
Country:			
Above Address is:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	
Phone:			
Email:			

Occupation (select one category – best match)	Specialty (select one category – best match)
<input type="checkbox"/> Physician	<input type="checkbox"/> Radiology
<input type="checkbox"/> Imaging Informatics Director	<input type="checkbox"/> Cardiology
<input type="checkbox"/> PACS/RIS Administrator	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Enterprise Imaging Manager/Architect	<input type="checkbox"/> Enterprise IT
<input type="checkbox"/> IT Manager/Director	<input type="checkbox"/> Information Systems
<input type="checkbox"/> C-Level Administrator (CEO, CFO, CIO, CMO, CMIO)	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Clinical Applications Professional	<input type="checkbox"/> Oncology
<input type="checkbox"/> Healthcare Administrator/Director	<input type="checkbox"/> Pathology
<input type="checkbox"/> Scientist/Researcher/Physicist	<input type="checkbox"/> Veterinary Medicine
<input type="checkbox"/> Student	<input type="checkbox"/> Other _____
<input type="checkbox"/> Developer/Engineer	
<input type="checkbox"/> Educator	
<input type="checkbox"/> Vendor/Consultant	
<input type="checkbox"/> Association Professional	