APPLICATION FOR MEMBERSHIP

Name: Dr. __  

Position or Job Title: ____________________________

Employer or Company: ____________________________

Contact Information:

Street Address ____________________________  P.O. Box / Mailstop ___

City ____________________________  State ____________________________  Zip Code ___

Phone Number ____________________________  E-mail Address ____________________________

This address is my __ home  __ work address. An e-mail address is required to receive the chapter newsletter.

Affiliations and Certifications

__ American Association for the Advancement of Science
__ American Association of Physicists in Medicine
__ American Academy of Health Physics
__ American Board of Health Physics Certified
__ American Conference of Governmental Industrial Hygienists
__ American Nuclear Society
__ American Industrial Hygiene Association
__ American Physical Society

American Public Health Association
__ Conference of Radiation Control Program Directors Health Physics Society
__ National Registry of Radiation Protection Technicians Certified
__ Radiation Research Society
__ Society of Nuclear Medicine
__ Other: ____________________________

Membership categories and annual dues are shown below.

Please indicate the type of membership you are requesting.

☐ Plenary ($35.00)  ☐ Student ($20)
☐ Fellow ($25.00)  ☐ Emeritus ($20)
☐ Affiliate ($200)  ☐ Group ($30 per person)

Signature ____________________________

Date ____________________________

Make checks payable to:
Cascade Chapter Health Physics Society or CCHPS

MAIL - Return this form and/or membership dues to:
CCHPS c/o James Tarpinian
7342 Baltray Pl. SW
Port Orchard, WA 98367

ELECTRONIC – Email this application to Chapter Treasurer.
Membership dues can be paid electronically via email invoice.

James Tarpinian
cascadechapterhps@gmail.com