





# APPLICATION FOR MEMBERSHIP

## Membership Details and Payment

Professional Membership

1 YEAR - \$125 USD

3 YEARS - \$300 USD

Voluntary Donation  
TOTAL

Please consider a gift in support of the ICMS

\$ \_\_\_\_\_  
\$ \_\_\_\_\_

Check Enclosed --- *Payable to International Cellular Medicine Society*

MasterCard

VISA

American Express

Cardholder's Name \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Sec Code \_\_\_\_\_ Exp Date (MM/YY) \_\_\_\_\_

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Contributions and gifts made to the ICMS may be deductible as charitable contributions for federal income tax purposes. Dues payments may be deductible by members as an ordinary and necessary business expense. Consult your tax advisor for further information.

### ALL APPLICATIONS MUST INCLUDE CHECK OR CREDIT CARD PAYMENT

If your application for membership is declined, your dues payment will be refunded.

### PROFESSIONAL AND CORPORATE APPLICATIONS MUST INCLUDE A RESUME OR CV

Membership Applications that are not accompanied by payment and resume/CV will not be processed.

### YOUR INTERESTS AND ACTIVITIES RELATED TO ADULT STEM CELL MEDICINE

1. Are you currently involved in the use of stem cells or other cell based products as part of the practice of medicine? If so, briefly describe the source of the cells (autologous or allogeneic) and how they are being used.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are the stem cells being used cultured?

\_\_\_\_\_

3. Has your treatment been reviewed and/or approved by an institutional review board? If yes, please list the institutional review board that has approved this treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### RETURN THIS FORM TO:

International Cellular Medicine Society, PO Box 4423, Salem, OR 97301 USA  
(503)400-5603, info@cellmedicinesociety.org, www.cellmedicinesociety.org

Federal Tax ID#: 75-2985553