



# Membership Form

**NAME:** \_\_\_\_\_  
**TITLE:** MD DO PA NP RN  
**ORGANIZATION:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**OFFICE PHONE:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**OFFICE FAX:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**OFFICE EMAIL:** \_\_\_\_\_  
**WEB LINK:** WWW. \_\_\_\_\_

**Do you want the above information posted to the WSANS website?** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

**PRIVATE INFORMATION (OPTIONAL)**  
**Shared only with WSANS board and other members:**

**MOBILE:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**PAGER:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**PERSONAL EMAIL:** \_\_\_\_\_

**Will you be attending the annual meeting?** \_\_\_ **YES** \_\_\_ **NO**

**2010 DUES Assessment** **\$100.00**

Please make check payable to:  
Washington State Association of Neurological Surgeons

Return this form, a business card and your check to:  
Dr. Farrokh Farrokhi  
% Rosalie Thorpe  
Harborview Medical Center  
325 9<sup>th</sup> Avenue  
Box 359924  
Seattle, WA 98104-2499