

**SOUTH CAROLINA
GASTROENTEROLOGY ASSOCIATION
ALLIED HEALTH MEMBERSHIP APPLICATION**

P.O. Box 11188, Columbia, SC 29211, Telephone: (803) 798-6207 Fax: (803) 772-6783

Please print or type. Please mail your completed application with your \$100.00 dues to the address above.

Allied Health Members must be employed by an SCGA member. Allied Health members must possess one of the following certifications: RN, NP, CRNP, ANP, APN, LPN or PA.

Name: _____ / ____ / ____
(Last) (First) (MI) (Date of Birth)

Current Degree: _____

Practice Name: _____ Gender: M F

Position/Title: _____

Work Address: _____
(Street) (City) (State) (Zip)

Are you currently utilizing an Electronic Medical Record (EMR) system in your office? Yes No

Work Phone: _____ Fax: _____

Administrator's Name: _____ E-mail: _____

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ E-Mail: _____

Undergraduate Education: _____
(School) (Location) (Year) (Degree)

Advanced Education: _____
(School) (Location) (Year) (Degree)

Proposer Information (Required)

Your proposer must be your employer, and an SCGA Member. He/she will need to verify your employment each year before renewing your SCGA Membership.

Proposer's Name: _____

Proposer's Phone Number: _____ Email: _____

Proposer's Signature: _____

(Applicant's Signature)

(Date)

OFFICAL USE ONLY

Approved as an Allied Health member in good standing of the South Carolina Gastroenterology Association.
(circle category)

(Secretary of Association)

(Date)