Membership Application

Name_____ **Title**_____

Address_____

City_____ **State**_____ **Zip**_____

Work #_____ **Home #**_____

Cellular#_____ **Fax#**_____

Email_____ **Website**_____

Professional Affiliations_____

_____

Place of Practice or Employment Address_____

City_____ **State**_____ **Zip**_____

Are you a US Citizen? ☐ **Yes** ☐ **No**

(Please circle the one that applies to you)

Professional Member – MD, DO, DC, PhD	**$100.00**
Associate Member – Certified Thermographer	**$100.00**
Affiliated Member – All others	**$100.00**
Resident/Student Member	**$100.00**

Area of Study_____

Total Amount Enclosed $_____

Please submit this form with your check payable to:

IAMT
315 Doris Drive
Lakeland, FL 33813
1-800-709-9565

I have read and understand the IAMT Guidelines, Code of Ethics, Code of Practice and IAMT Policy Statements and I agree to uphold and abide by them. I also state that all of the information above is factual.

*Signature*_____ **Date**_____