General Thoracic Surgical Club

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Membership Renewal Form

First Name: _____ Last Name: _____ Designation(s):_____

Company/Institution:_____

Department:_____

Address:_____

City: _____ State:_____ Zip:_____ Country: _____

Phone:_____Email:_____

Membership Type: _____

Member Type	Yearly Membership Dues
Active Member	$395
Candidate Member	$50

Please Check All that Apply:

□ Physician □ Researcher □ Physician Assistant □ Industry Professional □ Resident

□ Student □ Fellow □ Healthcare Professional □ Other:_____

Payment Information

Total Amount Due:_____

Payment Type: □ Visa □ MasterCard □ American Express □ Check No.

Credit Card #:_____ Exp:_____ CVV:_____

Signature_____

Name (clearly written):_____