Society of Correctional Physicians
2012 Annual Conference

Print your name as you wish it to appear on your badge and other correspondence.

Name: _____Degree(s)_____

Job Title: _____ Place of Work: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Mobile: _____ Email: _____

Membership Fees

Please ☐ begin / ☐ renew my membership in the Society of Correctional Physicians.....$125

Meeting Fees	**Thru 10/12**	**After 10/12 & Onsite**
☐ SCP Member.....	$150	$175
☐ Nonmembers.....	$200	$225

Total Enclosed: _____

Payment Information

☐ Enclosed is my check made payable to the Society of Correctional Physicians (SCP).

Please bill my ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Card #: _____ Expires: _____

Signature (for credit card payment only): _____

Billing Address (if different than above): _____

For New and Renewing Members

By my signature, I attest that I am a doctor of medicine or osteopathy who holds a license to practice medicine by an appropriate board of licensure that does not limit my practice solely to the correctional setting, and am engaged in the practice, teaching or research of correctional medicine. I certify that my renewal application as submitted is true and correct. I agree to comply with SCP's bylaws and code of ethics.

Signature: _____ Date: _____

Return this registration form, along with payment, to:

Society of Correctional Physicians
1145 W. Diversey Pkwy.
Chicago, IL 60614
Phone: (800) 229-7380 · Fax: (773) 880-2424