



Individual Membership Application - International

Today's Date _____

A division of Medical Staff S.O.S., Inc.

*Please **print** your name EXACTLY as you would like it on your diploma/certificate (if applicable):*

Please use a separate form for each person

First _____ Middle Initial _____ Last _____

Job Title _____ Credentials (if any) _____

Are you credentialed through other organization(s)? If yes, which one(s) _____

What is your renewal date with above organization? _____

Home Address: _____

City _____ Country _____ Zip _____

Home Phone _____ Mobile Phone _____

Practice/Company _____

Address _____

City _____ Country _____ Zip _____

Office Phone _____ Fax _____

E-mail address _____

How did you hear about PHIA? _____

Insert Photo ID here

Individual Membership: \$125.00

Method of Payment: Wiring _____

MC/Visa/Discover/Diners Club (Circle one) Expiration date _____ Billing Zip Code _____

Card Number _____ Security Code _____

Name on Card _____ Signature _____

E-Mail this form to: Sherry@phia.com OR Fax : 502-473-8807

Questions Call: 502-473-8806 U.S. * 866-473-3036 Toll Free
Email: MSSOS@PHIA.com or visit us at www.PHIA.com