

Louisiana Academy of Sleep Medicine
Individual Membership Application

Please provide all of the requested information.

New Member Renewal Membership

Name _____

Home or Work Address _____

City _____ State _____ Zip _____

Date of Birth: _____ Gender: _____ Male _____ Female

Company/Hospital Affiliation: _____

Telephone: (_____) _____ Fax: (_____) _____

Cell Phone: (_____) _____ Pgr# (_____) _____

Email address: _____

Degree(s) – Please Circle

1. MD 2. PhD 3. MD/PhD 4. RPSGT 5. DO 6. DDS 7. Other _____

Primary Specialty – Please Circle

A. Sleep B. Neurology C. Pediatrics D. Psychology E. Internal Med F. Neuroscience
G. Psychiatry H. Pulmonary I. Dentistry J. ENT K. Other _____

Are you currently an Accredited Sleep Center/Lab: _____

Membership Classification (select one):

- Category A: Doctoral Member (M.D., D.O., Ph.D., or DDS) who has received Board certification by the American Board of Sleep Medicine.
- Category B: Registered Polysomnographic Technologist.
- Category C: Doctoral Member (M.D., D.O., Ph.D., or DDS) who has not received Board certification in Sleep Medicine, but has demonstrated interest and involvement in sleep medicine.
- Category D: Polysomnography technicians (not registered), respiratory therapists, EEG technicians, nurses, students and others who have demonstrated interest and involvement in sleep medicine that are approved for Membership by the Membership Committee.

**Would you like your name listed on our online membership roster? YES OR NO

Mail application and check or money order for \$25.00 to:

LASM, PO BOX 10185, New Orleans, LA 70181

Office Use Only

Date Rec'ed _____ Amount: _____

Received by: _____ Date: _____

Forward to: _____ Date: _____

New Membership packed mailed _____ Date & Initials: _____