



MEMBERSHIP APPLICATION 2008

Biographical Information (please print)

Last Name: _____ First Name: _____

Credentials: RPSGT # _____ Physician Other: _____

Are you currently performing polysomnographic procedures? Yes ___ No ___

Are you currently practicing sleep medicine? Yes ___ No ___

Polysomnography Student (Dates enrolled : _____)

Professional Address (please check which address to send correspondence)

School/Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Home Address

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Annual membership dues are \$30.00 and renewable every January.

METHOD OF PAYMENT:

Please make check / money order payable to NCAST (U.S. funds drawn on a U.S. bank) *No cash accepted*

Signature: _____

Mail Application and dues to:

NCAST

PO Box 80726

Raleigh, NC 27623