



Connecticut Sleep Society Membership Application

Name _____

Address _____

City _____

State _____

Zip _____

Membership Type: _____

Amount Enclosed: \$ _____

Payment Method: _____

Check # _____

Credit Card # _____ Exp Date: ____/____

Professional Membership: RPSGT or RRT

Physician Membership: PhD, MD, DMD

Please include \$25 for annual dues for Professional or Affiliate membership

Please include \$50 for annual dues for Physician membership

Applications received without application fee will be denied.

Mail this completed form with application fee to:

CONNECTICUT SLEEP SOCIETY

Attn: Membership

PO Box 1043

Avon, CT 06001