



VETERINARY NEUROSURGICAL SOCIETY MEMBERSHIP FORM

Title _____ First Name _____ Last Name _____

Email _____

Position/Title _____

Institution/Practice _____

Practice Type _____

Professional Interests _____

Work Address:

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Fax _____

This is my preferred mailing address

Home Address:

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Fax _____

This is my preferred mailing address

Membership Preference:

General Member (\$50)

Renewing Membership (\$50)

Resident/Intern/Student (\$25)

Please Mail form and payment to:
Veterinary Neurosurgical Society
5671 Crooked Stick Drive
Wadsworth, OH 44281