WOMEN IN SCIENCE, DENTISTRY, AND MEDICINE (WISDM)
FACULTY ORGANIZATION
Membership Application

Name: __________________________________________
(last, first, mi)                                Degree(s): _____________________________________
Work Address: __________________________________
Home Address: __________________________________
City/State/Zip: __________________________________
Home Phone: ____________________________________
Department: ____________________________________
City/State/Zip: __________________________________
Work Phone: ____________________________________
Fax: ___________________________________________
Position: ______________________________________
E-mail: _________________________________________

Are you interested in participating as a WISDM Liaison to your department?
___yes  ___no   If yes, which department and division ________________________________

If you are interested in WISDM Committee participation, please indicate which committee.

☐ Graduate Student Liaison   ☐ Nominating
   (WIS Student Organization)   ☐ Professional Achievement Award
☐ Housestaff Liaison        ☐ WISDM Book Club (planning & logistics)
☐ Medical Student Liaison   ☐ Professional Development
   (WIM Student Organization)   • Seminars
☐ Membership                   • Annual conference

Membership Categories:
Members: All faculty (clinical, basic science, administrative, full-time, part-time, any rank), students, housestaff, fellows, and post-docs in the VCU Schools of Medicine and Dentistry are considered members of WISDM and are invited and encouraged to participate in any and all events and meetings.

1. Lifetime Members: Any faculty member, student, housestaff, fellow, post-doc, retired faculty, alumni, or interested colleague at the VCU Medical Center who pays the one-time contribution to sustain and support our various programs is a lifetime member.     Lifetime Member: $100 (one-time contribution)

All funds are used to support professional development activities of the VCU WISDM Program.

Please indicate: ___Faculty member  ___Dental student  ___Graduate student  ___Medical student
   ___SOM  ___Housestaff  ___Fellow  ___Postdoc
   ___SOD  ___Other, please indicate ____________________________________________

Make check payable to: WISDM  Send this form and payment to:
Dr. Jennifer Koblinski, WISDM Faculty Organization
P.O. Box 980662, Richmond, VA 23298-0662