

Technological Echo Association of Milwaukee

MEMBERSHIP APPLICATION

Personal Information

Full Name: _____
Last First M. I.

Address: _____
Street Address Apartment/Unit #

_____ *City State Zip Code*

Home Phone: _____ Alternate Phone: _____

Please check appropriate box below:

- ACTIVE SONOGRAPHER / Credentials-Registry Number:_____**
- ASSOCIATE (non-credentialed, associated with echocardiography)**
- STUDENT (currently in a echocardiography program/Include copy of school ID)**

Job Information

Title: _____ Specialty: _____

Special Skills _____ Department: _____

Work Location: _____ E-mail Address: _____

Work Phone: _____ Cell Phone: _____

Contact us at TEAM, PO Box 240851, Milwaukee, WI 53224 Telephone: 414-219-5563



Membership Fee

Physician / Sonographer / Associate: \$25.00
Student: \$15.00

Renewal_____ New Membership_____

Please make checks payable to:
TEAM, C/O Laura Johnson

Mail application w/check to:
PO Box 240851, Milwaukee, WI 53224

I am interested in volunteering