

Information:

Drawer: Accounts Payable - Invoices

Vendor Number: 1382512

Vendor Name: Society of Diagnostic Medical Sonograph

Invoice Number: 022322

Invoice Date: 2/23/2022

PO Number:

Check Number: 0297374

Check Amount: \$ 250.00

Check Date: 03/15/2022

Voucher Number: V0732065

Document Type: AP Invoice

Document Below



SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL MEMBERSHIP APPLICATION

Organization Name College of DuPage

Address 425 Fawell Blvd

City Glen Ellyn State/Province il Zip+4/Postal Code 60137

Country _____ Website cod.edu/sonography

(if not US)

Primary Contact Lisa Vondra

First _____ MI _____ Last _____

Email (required) rajchell@cod.edu

Daytime Phone (630) 942.3050 ext. _____ SDMS # 76187

SDMS ORGANIZATIONAL MEMBERSHIPS	OPTIONS AVAILABLE				
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Annual Membership Dues (USD)	\$250	\$750	\$1,400	\$3,250	\$6,000
Includes: SDMS Standard Memberships	0	5	10	25	50
Discount: SDMS CME Activity Application Fees (Includes SDMS Clinical Instructorship CME Credit)	✓	✓	✓	✓	✓
Discount: SDMS Store	✓	✓	✓	✓	✓
Discount: SDMS Annual Conference Registrations	✓	✓	✓	✓	✓
Organizational JDMS Subscription (print only)		✓	✓	✓	✓
Discount: SDMS Organizational Professional Liability Insurance*			✓	✓	✓
Discount: SDMS Job Board Postings				✓	✓
SDMS Medal Level Recognition (guaranteed minimum of Bronze level recognition)					✓

* Coverage is not guaranteed. Must complete application and qualify through SDMS Insurance Services.

Membership Tier/ Dues: ☒ Tier 1/ \$250 ☐ Tier 2/ \$750 ☐ Tier 3/ \$1,400 ☐ Tier 4/ \$3,250 ☐ Tier 5/ \$6,000 \$ 250

Donation to the SDMS Foundation: ☐ \$50 ☐ \$100 ☐ \$250 ☐ \$500 ☐ \$1000 ☐ Other \$ _____ \$ _____

The Society of Diagnostic Medical Sonography (SDMS) Foundation is recognized by the Internal Revenue Service (IRS) as a tax exempt charitable organization described in section 501(c)(3) of the Internal Revenue Code. Your donation will be deductible to the extent permitted by law.

TOTAL: \$ 250

Indicate Payment (PLEASE PRINT)

☐ Credit Card Credit Card Number: _____ CID: _____ Expiration Date: _____

☐ Check/ Money Order

NOTE:
This form is valid
through 12/31/22

Cardholder's Name (as it appears on card) _____ Signature _____

Cardholder's Billing Address (as it appears on statement – Please include address, city, state/province, and zip/postal code) _____

Payment by check authorizes the SDMS to process funds by electronic funds transfer (ACH). Membership dues to the SDMS are not tax deductible as a charitable contribution. For information on partially deducting membership dues as a business expense, go to sdms.org/taxes. SDMS takes the privacy of your personal information very seriously and will use your information only in accordance with the terms of the SDMS Privacy Policy, available at: sdms.org/privacy

Please return completed two-page application with appropriate dues payment to:

SDMS Membership Department • 2745 Dallas Pkwy Ste 350, Plano, TX 75093-8730 • 800.229.9506 • +1 214.473.8057 • +1 214.473.8563 Fax



SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL BENEFICIARY FORM

This form must be used to add individual beneficiaries to your SDMS organizational membership. Please provide the requested information in the table below for each individual receiving SDMS membership benefits under the organizational membership. A membership application must be provided for each beneficiary who is not a current SDMS customer.

Beneficiary List (attach additional pages with this section's information if needed for more beneficiaries)

Beneficiary Name (First & Last)	Email Address	Date of Birth	ARDMS # (if applicable)	SDMS # (if applicable)
		__/__/__	_____	_____
		__/__/__	_____	_____
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		__/__/__	_____	_____
		__/__/__	_____	_____
		__/__/__	_____	_____
		__/__/__	_____	_____

Primary Contact Affirmation

As the primary contact for this SDMS organizational membership, I hereby attest that I have the authority to give consent for the contacts listed above to receive SDMS communications (i.e., email and physical mail). I understand that each contact listed above may subsequently make changes to their personal communications preferences in the "My Profile" area of the SDMS website (sdms.org/membership/manage-membership/my-profile). I understand that beneficiary information must be provided within 2 months of initial membership and may only be changed during future open enrollment periods, beginning 90 days prior to the organization's membership expiration date through the expiration date.

Signature: _____ Date: _____

Please return completed two-page application with appropriate dues payment to:

SDMS Membership Department • 2745 Dallas Pkwy Ste 350, Plano, TX 75093-8730 • 800.229.9506 • +1 214.473.8057 • +1 214.473.8563 Fax

"Lang, Jessica" <langj@cod.edu>

SDMS Invoice \$250.00

"Lang, Jessica" <langj@cod.edu>

Wed, Feb 23, 2022 at 09:07 PM GMT

CC:

BCC:

Good Afternoon,

Please be sure to send the attached membership renewal form along with the check. This should be taken out of GL #:01-10-00157-5401002.

Thank you,

Jessica Lang

Program Support Specialist, Health Sciences

College of DuPage | 425 Fawell Blvd | Glen Ellyn, IL 60137

630.942.2447 Direct | 630.942.8331 Office | 630.942.4222 Fax

langj@cod.edu

1 attachment

SDMS \$250.00 - sent to AP 2.23.22.pdf