



Cardiac Neurodevelopmental Outcome Collaborative

INSTITUTIONAL MEMBERSHIP APPLICATION

PLEASE PRINT OR TYPE

Institution Name _____

Billing Address _____

City _____ State _____ Country _____ Zip/Postal Code _____

Billing Contact _____ Email _____

Title _____ Office phone _____

CNOC CLINICAL REGISTRY

Clinical Lead for CNOC _____ Email _____

Title _____ Office phone _____

Administrative Contact _____ Email _____

Title _____ Office phone _____

Data Entry / Collection _____ Email _____

Title _____ Office phone _____

**Email is required to receive future membership information. Please print clearly for successful email delivery.*

Annual Institutional Membership provides UNLIMITED AFFILIATED MEMBERSHIPS to your staff.

Attach an Affiliated Staff Application (page 2) for each staff member, or ask them to complete the application found at this link: https://secure.societyhq.com/cnoc/aff_app.html

PLEASE NOTE: So that your Member Institution can be featured properly, please forward to cnoc@cardiacneuro.org a vectored eps logo for your institution or specific program and the link to the program you wish to highlight.

MEMBERSHIP CATEGORIES

Institutional Membership Dues total \$7,500 annually. The manner in which your institution is invoiced is based on your participation with the Pediatric Cardiac Critical Care Consortium (PC4).

My institution is also a member of PC4 (Pediatric Cardiac Critical Care Consortium).

My CNOC dues total \$7,500. I have enclosed payment to CNOC for \$3,500 with the balance to be invoiced separately in increments of \$2,000 by Cardiac Networks United and \$2,000 by ArborMetrix.

My institution is not currently a member of PC4 (Pediatric Cardiac Critical Care Consortium).

My CNOC dues total \$7,500. I have enclosed payment to CNOC for \$5,500 with the balance of \$2,000 to be invoiced separately by Cardiac Networks United.

PLEASE NOTE: So that your Member Institution can be featured properly, please forward to cnoc@cardiacneuro.org a vectored eps logo for your institution or specific program and the link to the program you wish to highlight.

SEE PAGE TWO FOR PAYMENT OPTIONS.

CARDIAC NEURODEVELOPMENTAL OUTCOME COLLABORATIVE

2209 Dickens Road • Richmond, VA 23230-2005 • (804) 565-6397 • Fax (804) 282-0090
liz@cardiacneuro.org • www.cardiacneuro.org



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INSTITUTIONAL MEMBERSHIP APPLICATION

FOR INTERNATIONAL INSTITUTIONS

International Institutional Membership: For institutions outside of the US and Canada.

Individual Tiers:

- Tier 1: \$700 (For institutions outside of the US and Canada.) Tier 2: \$450
 Tier 3: \$200 Tier 4: \$100

International members will receive the following benefits:

1. Committee membership and leadership opportunities
2. Special Interest Group (SIG) participation
3. Discounted registration for CNOCC Annual Scientific Sessions (not applicable to 2023 8th World Congress of Pediatric Cardiology and Cardiac Surgery)
4. Collaborative research and quality improvement opportunities within the cardiac neurodevelopment community
5. Task force and recommendation statement participation opportunities
6. Access to educational webinars, both live and archived, on clinical, research, and patient/family-relevant topics in cardiac neurodevelopment and psychosocial functioning

The tiered dues categories are based on the World Bank of Economies, and are adjusted from the rates for USA and Canada members due to barriers precluding participating in the clinical data registry.

DUES PAYMENT OPTIONS

- Payment by check or money order payable in US funds to **CNOCC**. If paying by check, you **MUST** include a copy of this application with your payment.
- Payment by wire. For international institutions outside of the United States, please email our office for wiring instructions.
- Payment by credit card.
- AmEx Mastercard Visa Discover

Name on Card: _____

Expiration Date: _____ Card Number: _____ CVV Security Code*: _____

Signature: _____ Date: _____

*CVV code is the three-digit number on the back of VISA, MC or Discover or four-digit number on the front of AMEX card above the account number.

If you do not receive a confirmation e-mail from the CNOCC office within seven days of submitting your membership application, please call the office to confirm that the documents have been received.

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AFFILIATED STAFF APPLICATION

Return this completed form with the Institutional Membership Application.

PLEASE PRINT OR TYPE

I am: Male Female

Last Name _____ First Name _____ MI _____ Degree _____

Position at Institution _____

Institution _____

Office Phone _____ Fax _____

E-Mail* _____ Year of Birth _____

Mailing Address _____

City _____ State _____ Country _____ Zip/Postal Code _____

Home Phone _____ Mobile Phone _____

** Email is required to receive future society information. Please print clearly for successful email delivery.*

Please indicate your specialty (you must choose at least one):

- | | | |
|--|---|--|
| <input type="checkbox"/> Adult Congenital Cardiologist | <input type="checkbox"/> Neonatologist | <input type="checkbox"/> Physician, other |
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Cardiac Surgeon | <input type="checkbox"/> Neuropsychologist | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Child Life | <input type="checkbox"/> Neuroradiologist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Nurse | <input type="checkbox"/> Therapist: Occupational |
| <input type="checkbox"/> Developmental Pediatrician | <input type="checkbox"/> Nurse, Advanced Practice | <input type="checkbox"/> Therapist: Physical |
| <input type="checkbox"/> Educational Liaison | <input type="checkbox"/> Patient/Caregiver | <input type="checkbox"/> Therapist: Speech |
| <input type="checkbox"/> Intensivist | <input type="checkbox"/> Pediatric Cardiologist | <input type="checkbox"/> Other _____ |

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