EXHIBIT C
SCAI PHYSICIAN & CLINICIAN SERVICE POOL FORM

Date of Submission: ________________

Name: ____ Gender: _____________
(Last) (First) (Middle Initial)

Professional Title: ____ Race/Ethnicity: _______
(Optional)

Employer and Employment Setting: ____
(e.g. University, Clinic, Private Practice, Hospital, Government, Corporate)

Is this institution affiliated with a Healthcare System? _________Yes ____ No
If so, which one? ____

Contact Information: ____
(Preferred Email) (Preferred Phone – indicate Work/Home/Mobile)

Areas of professional interest in rank order

1. ___________________________________
2. ___________________________________
3. ____________________________________
4. ____________________________________

Areas of interest (please check all that apply)

- ❑ CME Review
- ❑ Communications, Social Media & PR
- ❑ Education
- ❑ Finance
- ❑ Governance
- ❑ Healthy Policy / PAC
- ❑ International Programs
- ❑ Journal / Publications
- ❑ Quality Improvement
- ❑ Mentoring & Professional Development
- ❑ Women's Activities

Years of SCAI Membership ___________

Previous/Current Offices held and service on SCAI or other Committees, Boards , Task Forces (List with dates, position and organization if other than SCAI)

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Other comments: ____

Please note that there are a limited number of available appointments each year, SCAI will work to engage each candidate as much as possible.

Please send the completed form to: membership@scai.org

Updated 11/18/2019