

Complete information about the ISCT and its membership benefits may be found on-line at www.celltherapysociety.org.

I. Contact Information

Name:		
Last	First	Initial
Designation:		
Institution:		
Address:		
City:	State:	Zip:
Country:	Telephone:	Fax:
Email:		
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female

2. Professional Information

Primary Area of Expertise	Highest level of Education
<input type="checkbox"/> Regulatory	<input type="checkbox"/> Medical Degree
<input type="checkbox"/> Clinical	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> Research	<input type="checkbox"/> Masters Degree
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Industry	<input type="checkbox"/> Other

ISCT is collecting the following data to complete our online members' directory. The purpose of the directory is to offer our members a methodology for contacting their peers and colleagues in the field. Your peers will be able to find you based on the information you provide.

Please complete the sections below, selecting the items that describe your institution, department activities or individual experience and expertise.

Institution Type (Select the best description of your employer's overall operations)	
<input type="checkbox"/> Hospital / Health Care Facility	<input type="checkbox"/> Contract Manufacturer
<input type="checkbox"/> Research Facility	<input type="checkbox"/> Commercial Supplier / Vendor
<input type="checkbox"/> Medical School	<input type="checkbox"/> Testing Laboratory
<input type="checkbox"/> Pharmaceutical / Biotech Company	<input type="checkbox"/> Contract Research Organization
<input type="checkbox"/> Blood Center	<input type="checkbox"/> Donor Center / Collection Facility
<input type="checkbox"/> Cord Blood Bank	<input type="checkbox"/> Tissue Bank
<input type="checkbox"/> Consulting Firm	<input type="checkbox"/> Other:

**Please submit your Application Form along with payment to
 Membership Coordinator, ISCT Head Office**
 375 West 5th Avenue, Suite 201, Vancouver BC V5Y 1J6 Canada
 Ph.: 604-874-4366 Fax: 604-874-4378 Email: isct@celltherapysociety.org

Job Category (Select the **best** description of your current job position)

<input type="checkbox"/> Director - Lab	<input type="checkbox"/> Director - Medical
<input type="checkbox"/> Clinician	<input type="checkbox"/> Fellow/Trainee
<input type="checkbox"/> Nurse	<input type="checkbox"/> Physician Extender
<input type="checkbox"/> Executive Management (e.g., CEO, COO)	<input type="checkbox"/> Researcher / Scientist
<input type="checkbox"/> Quality / Regulatory	<input type="checkbox"/> Consultant
<input type="checkbox"/> Manager / Supervisor	<input type="checkbox"/> Manager / Coordinator – Product / Project / Program
<input type="checkbox"/> Technologist / Bench staff - Manufacturing, Processing, Testing, Development	
<input type="checkbox"/> Other:	

Responsibilities and Activities (Indicate **all** activities for which you are directly responsible or activities you perform)

<input type="checkbox"/> Purchasing Decisions	<input type="checkbox"/> Policy Decisions
<input type="checkbox"/> Principle Investigator – Clinical Trials	<input type="checkbox"/> Regulatory Reporting
<input type="checkbox"/> Principle Investigator – Preclinical	<input type="checkbox"/> Regulatory Package Submissions
<input type="checkbox"/> Direct Patient Care	<input type="checkbox"/> Clinical Laboratory Operations
<input type="checkbox"/> Clinical Research	<input type="checkbox"/> Translational Research / Product Development
<input type="checkbox"/> Pre-Clinical / Laboratory Research	<input type="checkbox"/> Teaching / Staff Training
<input type="checkbox"/> Hiring Decisions	<input type="checkbox"/> Marketing / Finance
<input type="checkbox"/> Quality Assurance / Quality Control Activities	<input type="checkbox"/> Reimbursement / Billing Compliance
<input type="checkbox"/> Other:	

Technical Activities (Indicate **all** activities performed at your facility or in which you possess expertise)

<input type="checkbox"/> Cryopreservation / Thawing	<input type="checkbox"/> Cell Infusion / Transplantation
<input type="checkbox"/> Gene Transduction / Therapy	<input type="checkbox"/> Vector Production
<input type="checkbox"/> Cell Separation (Enrichment/Depletion)	<input type="checkbox"/> Cell Expansion / Activation
<input type="checkbox"/> Flow Cytometry	<input type="checkbox"/> Apheresis
<input type="checkbox"/> Immune Functional Assays	<input type="checkbox"/> CFU Assays
<input type="checkbox"/> Tumor Evaluation/Minimal Residual Disease	<input type="checkbox"/> Other:

Cell and Tissue Types (Indicate **all** cell types at your facility or in which you possess expertise)

<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Peripheral Blood Stem Cells
<input type="checkbox"/> Cord Blood	<input type="checkbox"/> Mesenchymal Stem / Stromal Cells
<input type="checkbox"/> Nonhematopoietic Stem Cells	<input type="checkbox"/> Muscle Stem Cells
<input type="checkbox"/> Neural Stem Cells	<input type="checkbox"/> Embryonic Stem Cells
<input type="checkbox"/> Pancreatic Islet Cells	<input type="checkbox"/> Dendritic Cells
<input type="checkbox"/> Effector T Cells	<input type="checkbox"/> Helper T Cells
<input type="checkbox"/> Regulatory T Cells	<input type="checkbox"/> Hepatocytes
<input type="checkbox"/> IPs Cells	<input type="checkbox"/> Other:

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Clinical Applications (Indicate **all** clinical applications that your facility supports or in which you possess expertise)

<input type="checkbox"/> Malignancy / Hematopoietic Diseases	<input type="checkbox"/> Primary Immune Deficiencies
<input type="checkbox"/> Autoimmune Diseases	<input type="checkbox"/> Metabolic Disorders
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Limb Ischemia / Wound Healing	<input type="checkbox"/> Neurology
<input type="checkbox"/> Sickle Cell Disease	

3. Membership Information

Please check type of 2010 Membership desired:

	Regular Rate	Technologist	Residents and Fellows*
Active Membership:	<input type="checkbox"/> \$175.00	<input type="checkbox"/> \$ 125.00	<input type="checkbox"/> \$ 80.00
E-Membership**:	<input type="checkbox"/> \$170.00 (\$114)**	<input type="checkbox"/> \$ 120.00 (\$80)**	<input type="checkbox"/> \$ 50.00 (\$33)**

* Must be accompanied by a letter from a program director/supervisor confirming student status.
 **New members receive 33% discount on E-Membership!

ISCT Membership is based on the calendar year (January 1 – December 31)

Yes, I am a new member to ISCT

Please extend this membership for 2 years:
 Those choosing a 2-year membership will be charged for both 2010 and 2011 at the 2010 membership rate, and receive receipts for both membership years immediately.
 If accepted into membership in ISCT, I pledge to foster and advance the principles and objectives which the Society represents, and to abide by its By-Laws.

Signature: _____ Date: _____

The signature field above may be used to insert a digital signature, created within Adobe Acrobat. If you do not have a digital signature, or do not wish to create one, you may also print, sign and fax the form to ISCT.

4. Payment Information

Check Payment

Checks should be made payable to: ISCT (in US funds drawn on a US bank) Fed. Tax ID No.: 52-1809771

Credit Card Payment

Card Type: MasterCard Visa American Express

Card No: _____ Expiry Date: _____

Name on Credit Card: _____

Signature: _____

The signature field above may be used to insert a digital signature, created within Adobe Acrobat. If you do not have a digital signature, or do not wish to create one, you may also print, sign and fax the form to ISCT.

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