

The Society for Participatory Medicine will grant a partial or full membership scholarship to any individual who demonstrates involvement in Participatory Medicine for whom the membership fee would be a burden.

PERSON YOU WISH TO NOMINATE INFORMATION

Name of individual
you wish to nominate:
(may include yourself) _____

Address: _____

City: _____

State/Province: _____

ZIP / Postal Code: _____ Country: _____

Telephone: _____

Email address: _____

PERSON MAKING THE NOMINATION (if different)

Name: _____

Address: _____

City: _____

State/Province: _____

ZIP / Postal Code: _____ Country: _____

Telephone: _____

Email address: _____

REASON FOR NOMINATION

Please mail to: The Society for Participatory Medicine
PO Box 1183
Newburyport, MA 01950-1183