

EXHIBIT C
SCAI PHYSICIAN & CLINICIAN SERVICE POOL FORM

Date of Submission: _____

Name: _____
(Last) (First) (Middle Initial)

Gender: _____

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. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Areas of interest (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> CME Review | <input type="checkbox"/> International Programs |
| <input type="checkbox"/> Communications, Social Media & PR | <input type="checkbox"/> Journal / Publications |
| <input type="checkbox"/> Education | <input type="checkbox"/> Quality Improvement |
| <input type="checkbox"/> Finance | <input type="checkbox"/> Mentoring & Professional Development |
| <input type="checkbox"/> Governance | <input type="checkbox"/> Women's Activities |
| <input type="checkbox"/> Healthy Policy / PAC | |

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)

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: Laura Hanson, lhanson@scai.org