



HAWAII THORACIC SOCIETY
Chapter of The American Thoracic Society

Membership Application

July 2009 – June 2010

Personal and Background Information

Name: _____
Last First Middle

Home: _____
Address

City State Zip Code

-(_____)_____
Telephone

Work: _____
Address

City State Zip Code

-(_____)_____
Telephone eMail

-(_____)_____
FAX Number

Position/ Title Professional Specialty

Membership information

How should we contact you? (Circle) Work Phone Email

Are you an American Thoracic Society Member? Yes No

Would you be willing to serve on an HTS committee(s)?
If yes, which one(s)?
___ Membership Committee
___ Nominating Committee
___ Government Relations/Health Care Committee
(joint with ALAH)

Please rate the various aspects of the Hawaii Thoracic Society described below, in terms of their value and importance to you. (*Grade each on a scale of 1-5 and circle the corresponding number.*)

(a) Professional Networking:

1	2	3	4	5
not valuable at all		somewhat valuable		very valuable

(b) Learning from Continuing Medical Education (CME) program/lectures:

1	2	3	4	5
not valuable at all		somewhat valuable		very valuable

(c) Meeting and learning from medical leaders and mentors:

1	2	3	4	5
not valuable at all		somewhat valuable		very valuable

(d) Continuation of the multi-day HTS Symposium:

1	2	3	4	5
not valuable at all		somewhat valuable		very valuable

Please add any comments/suggestions you would like to share:

Thank you for completing this HTS Membership Application. Please mail the completed form, your membership fee (\$75 for Physicians and \$35 for Allied Health Professionals), and the following Needs Assessment to the address below. *Checks should be made payable to the American Lung Association in Hawaii.* Mahalo!

Hawaii Thoracic Society
680 Iwilei Road, Suite 575
Honolulu, HI 96817

*HAWAII THORACIC SOCIETY
NEEDS ASSESSMENT 2009-2010*

HTS Member Name

HTS needs your help in obtaining information that will help identify the practice-related educational needs of physicians and allied health professionals in Hawaii. This information will be used by the HTS Continuing Medical Education Committee in planning future CME presentations. The annual Needs Assessment is also required in order to certify all CME activities, from evening presentations to major symposia. Please take a moment to fill out this form, so we can profile HTS education needs this year.

Please identify three clinical conditions for each question. Provide additional information if you wish, either adjacent to your response or on the reverse side of this sheet. Specific concerns about diagnostic procedures, clinical decision-making, and/or management strategies are particularly helpful to the committee.

Name three clinical conditions that you treat frequently and for which you would like to hear more about recent advances:

Condition 1

Condition 2

Condition 3

Name three clinical conditions about which you think patients are experiencing less than optimal outcomes:

Condition 1

Condition 2

Condition 3

Name three clinical conditions about which you would like to learn more:

Condition 1

Condition 2

Condition 3

Please suggest a possible speaker for a future CME presentation:

Name

Specialty

Location (Address)

Mail *Needs Assessment* along with Membership Application and dues to address below.

680 Iwilei Road Suite 575 • Honolulu • Hawaii • 96817 • Phone: (808) 537-5966 • FAX: (808) 537-5971
www.ala-hawaii.org • HTS@ala-hawaii.org