# AMERICAN THORACIC SOCIETY Membership Hardship Relief Program (MHRP) APPLICATION FORM

| First name | Middle initial(s) | Last name(s) | Degree(s) |
|---|---|---|---|
| | | | |

**CURRENT BUSINESS ADDRESS**
**Only if changed since onset of hardship situation**

_____
_____
_____
_____
**Tel:** _____
**Fax:** _____
**Email:** _____

**CURRENT HOME ADDRESS**
**Only if changed since onset of hardship situation**

_____
_____
_____
_____
**Tel:** _____
**Fax:** _____
**Email:** _____

As a member of the American Thoracic Society, I am requesting complimentary membership because my livelihood was severely negatively impacted by:

Please describe briefly how your livelihood was affected:

_____ _____
**Print your name here.** By printing my name, I attest that the statements made above are true to the best of my knowledge. I understand that the American Thoracic Society reserves the right to verify this information and to deny or terminate my participation in the MHRP. **Date**

**Please submit your completed application by email, fax, or postal mail:**

Attn: ATS Concierge
Membership Hardship Relief Program
American Thoracic Society
25 Broadway, 18th Fl.
New York, NY 10004 USA
Tel: +1 (212) 315-8684
Fax: +1 (212 315-8689
Email: membership@thoracic.org

FOR OFFICE USE ONLY:

☐Approved ☐ Denied Date:_____
Reason(s): _____
_____
_____
_____
_____

By: _____