



ICOT Membership Application

Name: _____

Job Title/Specialty: _____

Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

What are your expectations and what would you like to gain from your membership?

ICOT Membership Dues for 2023/2024

I am including payment of \$40.00 for an Individual ICOT Membership

I am including payment of \$80.00 for a Corporate/Agency ICOT Membership

**Please complete from,
include payment (check made payable
to ICOT) and mail to:**

ICOT c/o American Lung Association
Attn: Amy Huber
3000 Kelly Lane
Springfield, IL 62711

**If payment is with credit card, the following
fields must be completed:**

Name as appears on card: _____

Card number: _____

Expiration date: _____

Security code: _____

Billing address Zip code: _____