

THE ASA M SENSOR

Volume I, Number 2

April 1991

THE QUARTERLY NEWSLETTER OF THE
AMERICAN SOCIETY OF ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

President's Message...

by Dennis McMahon

"Nothing succeeds like success", but it has its price. The response to our membership campaign, the newsletter, and an article about the ASATT in two anesthesiology newsletters have combined to create a backlog of new member mailings; but our Membership Committee chairperson, Ruth Ochoa, has been burning the midnight oil to catch up with the overload. By the end of this month, all members will have received a membership certificate and card, a copy of the bylaws, a current membership roster, and minutes of the annual meeting. As we work toward our goal of better defined and better trained technicians, pertinent items will be sent to each member for your consideration and feedback.

Within the deluge of inquiries to the ASATT mail box, there are two frequent questions. One is: What is the difference between a technician and a technologist? The answer seems to depend on which dictionary you consult. Definitions tend to be blurred, but the term "technologist" generally refers to one who is knowledgeable in the applied sciences, while "technician" refers to one who is versed in the art and science of a specific profession. It may be a moot point; employer job descriptions seem to use these and other terms interchangeably. In the July issue of the *Sensor*, Ricki Kallish will report to us the results of her national survey of anesthesia techs, and we will see the spectrum of duties we all have, regardless of title.

The other frequent question concerns

formal training schools for anesthesia techs. The short reply is: There aren't any at present in the U.S. However, there are currently a number of community colleges, as well as the U.S. Navy, that are considering or actively preparing a curriculum for training anesthesia technicians. An article a future issue of the newsletter will elaborate on the current status of these programs. In the absence of formal training programs for our specialty, the best means of improving our value to patient care is continuing education through a local or regional anesthesia tech organization. *If there is a society in your region, take an active part in it; if there isn't any, form one.*

Finally, I'm happy to report that we have established formal liaisons with representatives of the anesthesia clinician community. As mentioned in an accompanying article, Dr Roger Litwiller, Director of ASA District 28, has accepted the role of ASA representative to the ASATT. Mr Curt Pudwill, CRNA, is our contact person in his position as chairman of the Council for Public Interest in Anesthesia, a committee of the American Association of Nurse Anesthetists (AANA). This month, these and other representatives of the clinical community will meet with members of the ASATT to offer recommendations on the specific function and training of anesthesia technical support personnel. The outcome of this and other collaborations with the anesthesia practitioners will be published in the newsletter. Stay tuned.

THE ASA RECOGNIZES THE ASATT

Roger W. Litwiller, M.D.
Director, ASA District #28
ASA Liaison to ASATT

The American Society of Anesthesiologists (ASA) welcomes the opportunity to develop a close relationship with the American Society of Anesthesia Technologists and Technicians (ASATT). Historically, the ASA has developed and maintained a close relationship with the Association of Operating Room Nurses (AORN) and the American Society of Post Anesthesia Nurses (ASPAN). Members of both of these organizations provide essential help to both the anesthesiologist and the patient who requires surgery. Such a relationship also exists with the members of the ASATT, anesthesiologists, and patients who require surgery.

To facilitate the establishment of this vital relationship, ASA has taken the following actions:

1) *Anesthesia technologists and technicians and members of the ASATT are welcome to register and attend the annual ASA meeting, beginning with this year's meeting which will be held October 26-30, 1991 in San Francisco, CA. The ASA annual meeting provides an excellent opportunity for anesthesia technologists and technicians to attend lectures and educational workshops. In addition, the ASA annual meeting features the largest number of exhibitors of any anesthesiology meeting. Therefore, it is an excellent place to learn about new anesthesia equipment and drugs. Since the ASATT annual meeting will be held October 25, 1991 in*

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1990 ASATT OFFICERS:

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L. Dianne Holley
1212 West 38th Street
Austin, TX 78705
512 323-1000 ext 4037

Employment Opportunities

MANAGER, ANESTHESIA SERVICES

Columbia Hospital, a 394-bed acute care hospital located on Milwaukee's East side, is seeking an individual to manage the human, material, and financial resources of the Department of Anesthesiology. Qualified candidates will have two to four years' experience as an anesthesia monitoring technician, sound management skills including planning, directing, budget, and finance. Must have a demonstrated ability to manage change and strong interpersonal skills.

We offer a highly competitive salary and benefits package. Please send a resume in confidence to: Sally Brenner, Employment Coordinator.

Columbia Hospital
2025 East Newport Avenue
Milwaukee, Wisconsin 53211

Columbia Hospital does not discriminate in employment or services.

HAVE YOU HUGGED YOUR ANESTHESIA TECH TODAY?



American Society of Anesthesia Technologists & Technicians

PLAN NOW FOR THE ASATT Annual Meeting October 24 & 25

details next issue



- Technical & Organizational Presentations
- Access to the ASA Meeting & Exhibit (with registration)
- Meet & mix with your fellow techs from across the country

Care & Feeding of Your Tech Society

COMMUNICATING WITH THE I.R.S.

John H. Armstrong, President
New York State Anesthesia Technology
Association
Post Office Box 18215
Rochester, New York 14618-0215
Phone (716) 334-0404

Have you ever heard of the three common lies told to people to gain their trust in their fellow man? The first is, "Your check is in the mail." The second is, "Hello, I'm from the federal government, and I'm here to help you." The third one is, (well, drop me a line and I'll clue you in).

You might have guessed already that it has been a great challenge to attempt to compete with the red tape of the Internal Revenue Service. We in the New York State Anesthesia Technology Association have been trying to establish our chapter as a tax-exempt organization in order to solicit contributions from vendors and prospective members.

The I.R.S. has the forms to send you. All you need to do is contact the right person who can distinguish what you do need from what you do not need, and forward the correct forms to you. Ask for the forms under subsection 501(C)(6), Form 1024, pages 1-5. In addition, you will need to complete:

1. Schedule C (found in 1024 booklet)
2. Form 8718, which amounts to nothing more than a cover page for completing Form 1024. On it you will state the fee you are enclosing for the processing of your application. (As big as we are in New York State, we sent in an association check for \$150).
3. S.S. #4 - Form for Employer Identification Number. This covers you if you ever hire someone to work within your organization. You also need the I.D. number in order to apply for tax-exempt status.
4. As part of your application process, on additional stationery, give the answers to the following I.R.S. questions:

[a] If your bylaws will act as your constitution, indicate that along with the signature of two of your officers.

[b] What percent of your association will be social in nature, and what percent will be professional? (In New York, we said 10% social and 90% professional.)

[c] Include, along with your application, a copy of your first newsletter, or the date on which you will be sending it.

Why the need for tax-exemption? Vendors and prospective members most often contribute if they know that their contributions are tax deductible. Also, when running a statewide organization, it is nice to know that the money you do take in will not be subject to taxation as income.

Helpful Hint: Do not accept the use of your state anesthesiologists society's

tax-exempt number (or anyone else's tax-exempt number) as your own. If they should, for some unknown reason, fail to thrive as an organization or association, your assets could be seized as part of their liquidation.

We still await our tax-exempt number, but have recently been told that our file is complete and is being sent to committee which will take another six to eight weeks before the permit is issued. I trust that the I.R.S. has not yet messed-up for the last time. If by the grace of the Almighty, His blessings should be bestowed upon us, we will have a "God Bless the I.R.S. Party of April 15, 1991" here at our address (hope the post office is open). We'll keep you posted.

SUGGESTED REFERENCE BOOKS FOR MEETING ORGANIZERS:

with library call numbers

Casselberry, M.: <i>How to Write Minutes</i> # 658.4563	Milo, F.: <i>How to Run a Successful Meeting</i> # 658.456
Devney, D.C.: <i>Organizing Special Events and Conferences</i> # 658.4563	Murray, S.L.: <i>How to Organize and Manage a Successful Seminar</i> # 658.4563
Dochterman, D.: <i>The Art of Writing Minutes</i> # 651.77	Riddick, F.M.: <i>Riddick's Rules of Procedure</i> # 060.42
Guy, D.G.: <i>How to Run a Meeting</i> # 060.42	Robert, H.M.: <i>Robert's Rules of Order</i> # 060.42
Jones, M.: <i>How to Organize a Meeting</i> # 658.4563	Wheeler, M.: <i>The Basic Meeting Manual</i> # 658.4563

HOW TO RUIN AN ORGANIZATION

1. Attend very few meetings. When you do attend, arrive late and leave early.
2. When at a meeting, vote to do everything, then leave and do nothing.
3. Benefit as much as possible from the organization, but never give the organization anything in return.
4. Talk cooperation, but don't cooperate.
5. When asked to help, always say that you haven't got time.
6. Never accept an office; it's easier to criticize than to try to accomplish things.
7. If appointed to a committee, never give any time or service.
8. Don't do anything more than you have to; and when others volunteer their abilities to promote the cause, gripe that the organization is run by a clique.

Advances in Pain Management

J. Lowell Haro, M.D.
Director, Pain Management Services
Capitol Anesthesiology Association,
Austin, TX

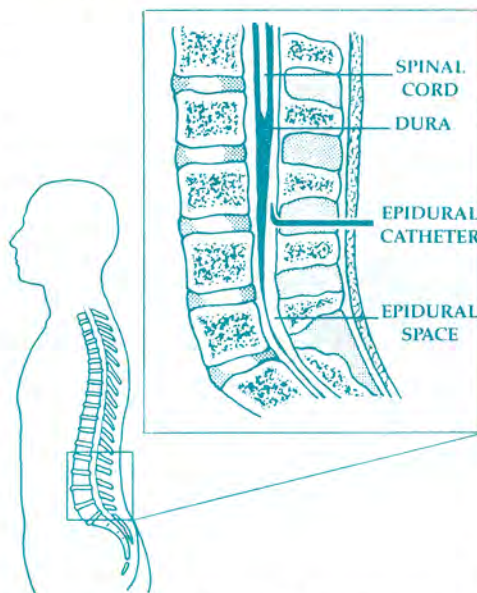
L. Dianne Holley
Chief Anesthesia Technician
Seton Medical Center, Austin, TX

Pain management is the fastest growing subspecialty in anesthesiology and will become more widespread in the decade of the nineties. As the physiology of pain is better understood, corresponding technological advances enable the anesthesiologist to control pain more effectively. Once this area was limited to post-operative injections or analgesic pills. However, the old "no pain, no gain" formula for post operative recovery is no longer a necessary or desirable philosophy among today's medical experts. Even long-term pain control is being tackled as more emphasis is being placed on relieving pain as well as curing the underlying medical problem. In fact, pain is sometimes a pathological condition rather than a symptomatic state.

Post-operative pain and chronic pain are two types of pain that generally respond well to new methods of pain control. For post-operative pain, the anesthesiologist uses an epidural catheter to manage the patient's pain for several days after thoracic, abdominal, or major joint surgery. Chronic pain is more elusive and challenging. Some chronic pain is the result of a cancerous growth or an impingement of a tumor on nerves or other sensitive areas. Back pain constitutes a major category in chronic pain management and can be caused by disc disease and/or bone abnormalities such as arthritis. One type of pain is self-perpetuating: Reflex Sympathetic Dystrophy (RSD) is a pain syndrome without underlying disease that results from an imbalance in the sympathetic nervous system. Other types of pain, such as that due to vascular disease, are also amenable to pain control techniques.

A basic understanding of the anatomy of the nervous system is necessary to appreciate the rudiments of pain control, since both pain and pain control ultimately involve the nervous system. The nervous system consists of two major parts: the peripheral nervous system and the central nervous system.

The peripheral nervous system is composed of the nerves running from the extremities and other parts of the body to the spinal cord. Several aggregated networks of nerves, called ganglia, are also present in the peripheral nervous system. The central nervous system consists of the brain and the spinal cord. There are pain receptors in the spinal cord that can be blocked so that the pain impulses are not conducted to the brain. The spinal cord can be accessed directly by placing a needle (and sometimes a catheter) into the spinal fluid surrounding the spinal cord. Also, a catheter may be placed in the epidural space which is separated from the spinal cord by membranes. Drugs can be administered via these two routes to directly effect the spinal cord itself.



Several different types of injections and electrical stimuli have been shown to be effective in pain management. These different types are each suited for certain categories, intensities, and durations of pain. The injection that people are most familiar with is the local anesthetic. Lidocaine, procaine, bupivacaine, etc., are all local anesthetic drugs that provide a temporary block of painful impulses in the central or sympathetic nervous system. Local injections can be used for surgical or pain control procedures. By temporarily blocking a nerve impulse, an

anesthesiologist can diagnose the origin of a targeted pain. Also, local anesthetics can be useful tools in resolving Reflex Sympathetic Dystrophy because this self-perpetuating syndrome is circular in nature. By blocking the cycle the syndrome stops self-perpetuating and when the block wears off, the system frequently has been "re-set" correctly, similar to turning an errant computer off and then on again.

Other types of injections can provide long lasting pain relief. Narcotics have been shown to block pain receptors in the central and peripheral nervous systems, thus blocking pain impulses before they reach the brain. Narcotics are used most frequently in post-operative pain control and a single epidural injection can last up to 24 hours. Steroids can provide even longer pain relief, although not by directly blocking the pain receptors. Steroids are used for back pain to reduce swelling of nerves caused by disc disease or scar tissue. Steroids can reduce this swelling and the accompanying pain for days, weeks, or even permanently.

Anesthesiologists can use certain chemicals, electricity, heat, and in the future possibly a laser to permanently block pain impulses by destroying portions of the nerves involved in conducting the pain impulses. Used for this purpose, these chemicals and other modes are called neurolytics, and the procedure can provide relief for weeks, months, or indefinitely. Chemical neurolytics such as phenol or alcohol are injected in and around the targeted nerve to destroy a small portion of it. CT scan or fluoroscopy is used to help guide the placement of the injection needle. Electricity can be used both diagnostically and as a neurolytic. Again, fluoroscopy is used to place a needle that is electrically insulated (except the tip) by which low levels of electrical stimulation are used to locate and avoid motor nerves. Stimulation of a motor nerve causes it to fire or jerk, whereby the anesthesiologist can pinpoint its

location. Once the insulated needle is in place, increased electrical stimulation is used to heat up the tip (like a Bovie) and coagulate a pinpoint area of nerve tissue, 2-3 mm in diameter. Electrical stimulation has long been used to locate motor nerves for nerve blocks prior to surgery.

Milder currents of electricity can also be used to block a nerve impulse without damaging the nervous tissue. Transcutaneous electrical neural stimulation (TENS) uses external electrodes to produce a mild current along a nerve pathway and thus control pain. The theory is that a nerve can conduct only one impulse at a time. TENS creates a counter-impulse to the pain impulse and thus blocks it. The dorsal column stimulator uses internally applied electrodes (in the spinal column) to produce a similar effect. A low level of current allows the anesthesiologist to diagnosis the exact location of the affected nerve. The awake patient can tell the doctor when the tingling sensation he or she feels corresponds to the area in which pain is felt. This is usually a last resort for chronic back pain.

The surgical applications of nerve blocks give the anesthesiologist the expertise he or she now uses in advanced pain management. Spinal and epidural blocks have been used routinely as alternatives to general anesthetics. Since the anesthesiologist can gain direct access to nerves from the neck downward via the spinal or epidural route, this is frequently the choice for pain management. Post-operatively, a patient may be made more comfortable by being given a local anesthetic and/or narcotic through an epidural catheter. Depending upon the situation, a patient may receive repeat doses at prescribed intervals or a single bolus of a long-acting narcotic like Duramorph (morphine), or be provided with a medication pump.

The patient controlled analgesia (PCA) pump is a relatively new development that allows the patient to control the amount and frequency (up to a certain point) of his narcotic injections for pain relief. Although the pump is preset so that no more than a given amount of narcotic may be administered over a given period of time, the patient feels more in control of his pain relief and

uses less narcotic than he normally would if a nurse were administering the drug.

Besides narcotics, other drugs such as steroids, local anesthetics, or neurolytics may be administered via the spinal or epidural route for chronic pain such as disc disease. These procedures are named according to the site of entry, the targeted area, and the type of injectate. A lumbar epidural steroid (LES) is a steroid injected into the lumbar portion of the epidural space, usually to treat back pain. A caudal epidural block is a local anesthetic entering the epidural space from the caudal canal at the base of the spine in the tailbone.

Basically any peripheral nerve or ganglion can also be the target of pain management procedures. These, too, are named by location and injectate. The procedures usually block chronic pain from Reflex Sympathetic Dystrophy (RSD), cancer, or injuries to the extremities. The stellate ganglion block (SGB) is a local anesthetic administered to the sympathetic ganglion adjacent to the 6th cervical vertebra. This blocks sympathetic nervous system output to the face, shoulder, and arm and can help alleviate RSD. A celiac plexus block is used to help control cancer pain, especially cancer of the pancreas.

Trigger point injections involve breaking a self-perpetuating cycle, similar to RSD. However, trigger point injections involve a discrete area, frequently of muscle tissue (spasm) or connective tissue (scarring), that causes a nerve ending to fire. Steroids can be used to reduce the swelling involved in the spasm or scarring, or sometimes a local or even a "dry" needle can be used to break the cycle. The stimulus of the dry needle can cause the body to break a spasm by invoking an injury response which increases the blood supply. Acupuncture works by this same process of invoking the body's natural response, but also uses a generally unknown system of referred pain so that a trigger point can be found remote to the area of pain.

Several surgical procedures have been developed to treat more serious cases of long-term pain where oral analgesics are ineffective or are not tolerated. A

permanent epidural catheter can be left in place for several months. An incision is made over the spine and the catheter is tunneled under the skin to the anterior abdomen. This tunneling lessens the chance of infection in the spine and allows the patient to have access to the catheter. Also, a type of battery-driven, computer-regulated pump can be implanted and attached to a permanent spinal catheter (similarly tunneled). These pumps can operate for several years and can be refilled by a simple needle stick once a month. A spinal catheter is used for these pumps because the larger epidural space acts to dilute the effectiveness of the drug; after two to three months the epidural space tends to scar and limit the effectiveness of narcotics. Also a dorsal column stimulator is an implanted electrical generator which produces a low intensity electrical impulse through a tunneled electrode catheter (insulated except at the tip).

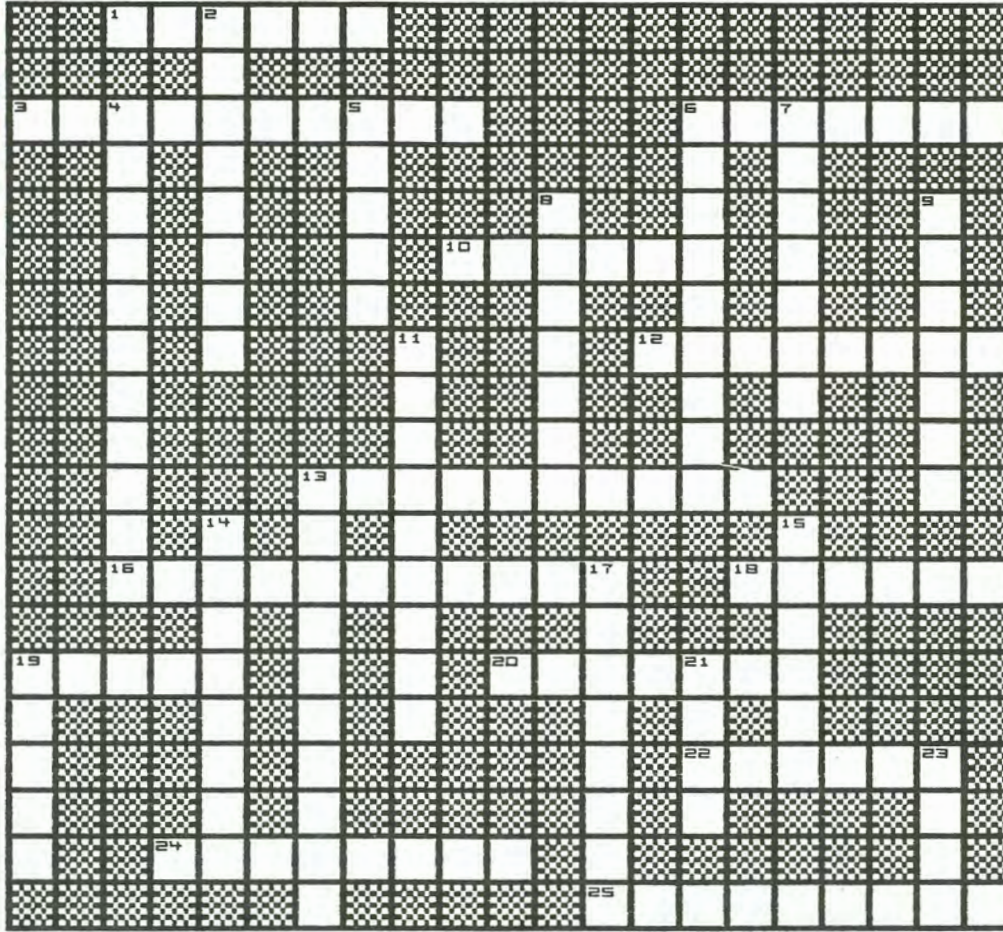
As the field of pain management grows increasingly complex, the benefits also increase for the post-operative and chronic pain patient. The patient's options for dealing with post operative pain are no longer only stoicism or being "doped-up"; and chronic pain sufferers needn't face "getting used to" their pain as their only possible future. Pain management is the fastest growing area in anesthesiology and will be a welcome option to an increasing number of patients.



TECHNICIAN

ANSWERS

by Dianne Holley



Answers to previous puzzle:

B
LIDOCAINE
O R A G
O R S L M
D TACHYCARDIA E U A
G Y P C G
A VENTRICULAR T O I
S H A I S L
M TRANSTRACHEAL
G P I D
JUGULAR I S C
I L BACTEREMIA
D M C Y I
E O O L C ATRIUM
W N U E O A
I A T T I D
R R Y P DAMPING
E Y U A
SYSTEMIC L

ACROSS

- Sympathetic blockades are used to treat ____ Sympathetic Dystrophies.
- Type of neural blockade that can be used to locate the source of pain.
- The classic neurolytic agent.
- Spinal cord stimulation is also called ____ column stimulation.
- ____ analgesia is also called neural blockade.
- ____ stimulation for pain management began in ancient times using certain fish or eels.
- ____ is added to local anesthetics to prolong their action.
- Simple solution frequently used in epidural puncture.
- Nonsteroidal anti-inflammatory drugs were first valued for their ability to reduce ____.
- Important nerve used to control pain in the leg.
- A neurolytic blockade acts by destroying portions of ____.
- Opiates act by binding to ____ sites.
- Common local anesthetic.

DOWN

- A opioid frequently used for anesthesia.
- An ancient Oriental medical practice with recent modern medical applications.
- Type of spinal needle with a curved tip.
- Absence of pain in response to that which would normally cause pain.
- ____ pain persists a month beyond its usual course.
- ____ point therapy is similar to acupuncture.
- One of the earliest analgesics derived from poppy plants.
- The least experience of pain one can recognize is a pain ____.
- Spinal cord stimulation involves implanting ____ in the spinal column.
- The most important type of headache because of its frequency and severity.
- Chronic pain that epidural narcotics are used to treat is ____ pain.
- Continuous ____ block is one of the most practical ways to manage pain.
- Curled position used for epidural/spinal needle placement.
- External electrical stimulation device.
- ____ temperature can be monitored to determine the effectiveness of a sympathetic block.

Reference: *The Management of Pain*
JJ Bonica, ed
Lea & Febiger, 1990

REGIONAL SOCIETY ACTIVITIES *Let us know what's happening in your area!*

Send a brief report of recent and future activities to the editor by June 21, 1991.

Photos (black & white, 3x5, captioned on back) are also welcome.

California -

The *California Association of Anesthesia Technologists and Technicians* is gearing-up for their annual meeting, May 17-19, in Anaheim. Topics during the 2½-day program will include basic patient preparation, occupational hazards, trauma, and ECG recognition, among others. Speakers will include MD's and techs as well as manufacturer representatives.

For further information:

Kathi Morgan at 408-299-6341.

Colorado -

The *Colorado Society of Anesthesia Technicians Short Course for Anesthesia Technicians* was held at Breckenridge last January 25-28, sponsored by the University of Colorado School of Medicine. The seminar was well received and well attended, with many techs from out of state.

For further information:

Jamie Blue at 303-270-8275.

Florida -

The *Florida Society of Anesthesia Technicians* has a full-day seminar planned for Saturday, July 14, in Orlando. Topics will include pulse oximetry, malignant hyperthermia, and trouble-shooting equipment. There will be a business meeting and election of officers, as well as vendor exhibits.

For further information:

Ed Vasquez at 407-872-6858.

Massachusetts -

The *Northeast Society of Anesthesia Technicians* is planning its a day-long meeting for mid-May in Worcester, MA to include hands-on sessions with anesthesia equipment. Announcements will be sent out within the New England area next month.

For further information:

Robert Newell at 617-789-3089.

New York -

The *New York State Anesthesia Technology Association* meets monthly in the Rochester area, with topics on anesthesia technology.

For further information:

John Armstrong at 716-275-5545 or George Mann at 315-464-4640.

North Carolina -

A preliminary meeting of anesthesia technicians is planned for April in Asheville, to explore the formation of a state/regional society.

For further information:

Kathy Meadows at 704-255-6142.

Ohio -

The *Ohio Society of Anesthesia Technicians & Technologists* is planning a full-day workshop for Saturday, April 27th, covering topics on infection control, preventative maintenance, and environmental safety.

For further information:

Wilma Frisco at 216-541-5710.

Texas -

The *Texas Society of Anesthesia Technology* held an informational and Q-&-A northeast regional meeting in Dallas on Saturday, March 23; the meeting was well attended and productive.

A meeting for central Texas is scheduled for 6 pm Wednesday, April 17, at Seton Medical Center, Austin. An organizational meeting for southeast Texas is planned for 10:30am Saturday, April 20, at St. Luke's Hospital, Houston. The first statewide meeting of the TSAT is scheduled in conjunction with the Texas Society of Anesthesiologists during the weekend of September 6-9, 1991.

For further information:

Dianne Holley at 512-323-1000, ext 4037.

Virginia -

There will be a meeting and election of officers for the newly-formed Virginia Anesthesia Tech Society on Saturday, April 13, in Charlotte. Speakers will include Dr Roger Litwiller (ASA liaison to ASATT) and Ricki Kallish (ASATT Region 2 Director).

For further information:

Linda Ferris, RN at 703-985-8351.

Washington -

The *Northwest Society of Anesthesia Technology* is scheduling its next quarterly meeting for 10am - 2 pm Saturday, April 27th, at Virginia Mason Hospital. A full-day seminar on anesthesia technology is planned for Saturday, July 27th, at the Four Seasons Olympic Hotel in Seattle. Topics will include invasive and non-invasive blood pressure monitoring, management of blood products, advances in pain therapy, and troubleshooting anesthesia machines.

For further information:

Lee Amorin at 206-223-4189.

Wisconsin -

By or in September, the first regional meeting of anesthesia techs will be held in Marshfield, to include organizational planning and educational presentations.

For further information:

Dean Rux at 715-387-7179

ASA Recognizes ASATT

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San Francisco, it will be convenient for ASATT members to attend the ASA annual meeting. The registration fee is \$50.00.

2) ASA President Betty P. Stephenson, M.D. has appointed Roger W. Litwiller, M.D., a member of the ASA Board of Directors, to be ASA liaison with the ASATT. Dr. Litwiller welcomes the thoughts of any ASATT member regarding the relationship between ASA and

ASATT. His address is:

*212 Highland Ave., SW
Roanoke, VA 24016
Phone (703) 345-0289
FAX (703) 345-9569*

The ASA salutes the ASATT and looks forward to seeing ASATT members at the 1991 ASA annual meeting in San Francisco in October.

MEMBERSHIP APPLICATION

(please print or type)

Last Name _____ First Name _____

Home Address _____

City _____ State _____ Zip _____
Province _____ Mail Code _____

Home Phone _____

Employer _____

Address _____

City _____ State _____ Zip _____
Province _____ Mail Code _____

Business Phone () _____ FAX Number () _____

May ASATT release your name to other members? YES NO

Are you a member of an ASATT-affiliated society? YES NO

If so, which society? _____

Membership Categories:

Active

\$ 45

Active, Member of Affiliated Society

\$ 30

Associate*

\$ 60

Corporate / Institutional*

\$100

*These categories provide all rights and privileges of active membership except holding office, chairing committees, and voting.

MAKE CHECKS PAYABLE TO ASATT

Signature _____

Date _____



American Society of Anesthesia Technologists & Technicians

P.O. Box 22492, San Francisco, CA 94122