



Application for Membership

Indiana Urologic Association, Inc.
1100 E Woodfield Road, Suite 350, Schaumburg, IL 60173
Phone: (847) 517-7225 u Fax: (847) 517-7229
Website: www.iuaweb.org

Prefix _____ Name _____ Suffix _____ Degree(s) _____ Gender _____

Office Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Home Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Email _____ Website _____ Date of Birth _____
(MM/DD/YYYY)

Preferred Mailing Address Office Home

I would like to apply for:

- Active Membership**
Qualifications: Active Membership in this Society is limited to licensed physicians of who reside and practice Urology in the state of Indiana and have an unrestricted license to practice medicine. \$100 payment of Annual Dues is required.
- Affiliate Membership**
Qualifications: Affiliate Membership in this Society includes licensed physicians in related fields of medicine and science who cannot qualify for active membership and Non-physicians who, by their professional or personal accomplishments have contributed significantly to medicine in general or the specialty of urology. \$100 payment of Annual Dues is required.
- Candidate Membership**
Qualifications: Candidate Membership in the Society is limited to residents in an accredited Urology training program within the state of Indiana. Such membership will terminate with completion or discontinuation of such residency training. Annual Dues are waived.

What area of subspecialty: (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="radio"/> Academics | <input type="radio"/> Endourology | <input type="radio"/> Female Urology | <input type="radio"/> Sexual Medicine |
| <input type="radio"/> General Urology Adults | <input type="radio"/> Male Infertility | <input type="radio"/> Pediatric Urology | <input type="radio"/> Urologic Oncology |

I hereby certify that the information on this application is correct. If accepted for membership, I hereby agree to abide by the Constitution and Bylaws of the Indiana Urologic Association, Inc.

Payment Information

- Check (Payable to IUA)
- Credit Card: Visa or MasterCard (Circle)
Card Number _____
CVV # _____
Expiration Date _____
Cardholder's Signature _____

Please forward application and fee / dues to:

Indiana Urological Association
Membership Department
Two Woodfield Lake
1100 E Woodfield Road, Suite 350
Schaumburg, IL 60173
Phone: (847) 517-7225 • Fax: (847) 517-7229
Email: info@iuaweb.org
Website: www.iuaweb.org