

# IAUA Application for Membership

Name \_\_\_\_\_ Sex M or F

Degree(s) \_\_\_\_\_ Preferred Mailing Address  Office  Home

Office Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Country \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Country \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Please check the box next to the type of membership you are applying for:

**Active Membership**

*Qualifications: Active Membership in this society is limited to licensed physicians of Indian origin who reside and practice urology in the US or Canada and has an unrestricted license to practice medicine.*

*Annual Dues: \$100 USD      Lifetime Membership: \$500 USD*

**Candidate (Associate) Membership**

*Qualifications: Associate Membership in the society shall be limited to residents and fellows in urology training.*

*Annual Dues: Waived*

**Corresponding (International) Membership**

*Qualifications: Physicians and other scientists who reside outside of the US and Canada, and who devote at least 75% of their total professional activities to the field of urology.*

*Lifetime Membership: \$100 USD*

**Affiliate (Scientific) Membership**

*Qualifications: a) Basic scientists who have their primary research effort in the field of urology and/or spend 75% of their working time in urology related endeavors; b) Non urologists who have contributed significantly to the specialty of urology.*

*Annual Dues: \$25 USD*

**What is your subspecialty? Check all that apply:**     Academics     Endourology     Female Urology  
 Sexual Medicine     General Urology Adults     Male Infertility     Pediatric Urology     Urologic Oncology

## Payment Information

Check (Payable to IAUA)

Credit Card: Visa or MasterCard (Circle)

Card Number \_\_\_\_\_

CVV # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

## Indian American Urological Association, Inc.

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Schaumburg, IL 60173

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Fax: (847) 517-7229

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Due to FCC regulations, we need your permission to fax or email you any information regarding your membership benefits and services. I give permission to the IAUA to fax/email me registration forms, dues statements, and other solicitations. 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 Indian American Urological Association, Inc.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_