APPLICATION FOR MEMBERSHIP --- THE IOWA UROLOGICAL SOCIETY

REQUIREMENTS FOR APPLICATION:

1. Membership fee - $10.00
2. Letters of recommendation by two members of the Society.
3. Letter from the Department Head of the Residency Program confirming completion of an approved urological residency.
4. Completion of the application form.

The above fee, letters, and form should be submitted to the Secretary-Treasurer of the Society. The completed application will be referred to the Board of Trustee's for approval.

Those admitted at the spring meeting will be assessed full annual dues for membership for that year and will be considered members for that year.

Those applying for membership at the fall meeting, who have completed residency that calendar year, may attend the fall meeting at the residents' fee and pay annual dues the following January. Those who have completed residency prior to the current calendar year will have paid non-member registration for the fall meeting and will pay regular annual dues the following January.

Please submit your completed application to:

James A. Brown, MD
200 Hawkins Dr., 3229 RCP
Iowa City, IA  52242
APPLICATION FOR MEMBERSHIP --- THE IOWA UROLOGICAL SOCIETY

Full Name: _____________________________________________________________

Email Address: __________________________________________________________

Address – Office: _________________________________________________________

Address – Residence: ______________________________________________________

Place of Birth: __________________________________ Date __________

High School: __________________________________ Date __________

College: _______________________________________________________________

Degree _______________ Date __________

College: _______________________________________________________________

Degree _______________ Date __________

Medical College: _________________________________________________________

Degree _______________ Date __________

Internship: ______________________________________________________________

Date _______ to _________

Residency: ______________________________________________________________

Date _______ to _________

License:    State _______ Number _______ Date _______ Expires ______

            State _______ Number _______ Date _______ Expires ______

Board of Urology: Date ______

Staff Positions: __________________________________________________________

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Signed: ___________________________

Approved: ___________________________, M.D.

_______________________________, M.D.

_______________________________, M.D., Chm., Board of Trustees