



Florida Urological Society Membership Application

Two Woodfield Lake 1100 E Woodfield Road, Suite 350 • Schaumburg, IL 60173
Phone: (847) 517-7249 • Fax: (847) 517-7229 • Email: info@flaurological.org

Membership Categories – check one

- ACTIVE MEMBERSHIP – \$175 annual fee:** (a) Receipt of a MD or DO degree at least five years before membership; (b) The applicant shall be eligible for the American Board of Urology or the American Board of Osteopathic Surgery and provide proof as same; (c) Letters of recommendation from two members of the Florida Urological Society; If the applicant is a member in good standing in the American Urological Association (AUA) and the Southeastern Section of the AUA, Inc. (SESAUA), letters of endorsement will be waived. (d) Attendance at an annual meeting within two years following the filing of his/her application and; (e) Limit his/her practice to teaching or clinical practice of urology.
- ASSOCIATE MEMBERSHIP – \$175 annual fee:** (a) Physicians residing in the State of Florida who limit their practice or have a special interest in Urology, may be nominated for Associate Membership; (b) Application for Associate Membership must be recommended by the Membership Committee and endorsed by the Executive Committee; (c) May apply for active membership when they fulfill the requirements.
- NP/PA AND ADMINISTRATORS MEMBERSHIP – \$50 annual fee:** NP/PA and Administrators membership is available to practice managers, physician assistants and nurse practitioners specializing in urology and not otherwise eligible for membership in the FUS. Application and renewal of membership requires sponsorship by an active or senior member of the FUS. NP/PA and Administrators members shall have all the privileges of active membership, but cannot hold office or vote.
- RESIDENT MEMBERSHIP - (Annual Dues: waived)** A resident currently in training in the Urological field in Florida, will be elected upon completion of an application and receipt of recommendation from the Chief of the residency program.

Applicant Information

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 _____

Medical/Academic Education

High School (NP/PA and Administrators applicants only) _____ Year Graduated _____

College _____ Year Graduated _____

City/State _____ Degree _____

Post Graduate Degree _____ Year Graduated _____

Medical School _____ Year Graduated _____

City/State _____

Internship _____ City/State _____

Residency _____ City/State _____

Fellowship _____ City/State _____

Check the following:

	Yes	No	Year
Diplomate American Board	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eligible to take examination of American Board of Urology	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have applied to take American Board of Urology	<input type="checkbox"/>	<input type="checkbox"/>	_____
Member, American Urological Association	<input type="checkbox"/>	<input type="checkbox"/>	_____
Member, Florida Medical Association	<input type="checkbox"/>	<input type="checkbox"/>	_____
Professional Liability Insurance Company (optional) _____			

Activities Since Residency – Active and Associate applicants ONLY (include places and dates of practice, teaching app., etc.)

Professional Activities Since Academic Education – NP/PA and Administrators applicants ONLY (attach additional sheets if necessary)

Years in urology/dates _____
Location _____
Associated with _____
Military service/branch/date of service _____
Allied society memberships _____
County _____
State _____
Other _____

Have you ever received an official censure or reprimand from a medical society? If yes, please explain.

Are you now or have you ever been party to malpractice litigation? If yes, please explain.

Letters of Recommendation – Active and Associate applicants ONLY

Give names and addresses of two members of the Florida Urological Society as references and ask them to write letters of recommendation for you. Please enclose letters with application.

Member name _____
Office address _____ City/state/zip _____
Member name _____
Office address _____ City/state/zip _____

If accepted for membership, I hereby agree to abide by the Constitution and Bylaws of the Florida Urological Society.

Signature of Applicant _____ Date _____

Payment Options

- Check (Payable to the Florida Urological Society)
- Credit Card (Circle): Visa MasterCard American Express

Card Number _____
CVV # _____
Expiration Date _____
Cardholder's Signature _____

Please forward application and supporting documents to:

Florida Urological Society
Membership Department
Two Woodfield Lake
1100 E Woodfield Road, Suite 350
Schaumburg, IL 60173
Phone:(847) 517-7249 Fax:(847) 517-7229
Email:info@flaurological.org