MEMBERSHIP APPLICATION

PLEASE TELL US ABOUT YOUR UROLOGY GROUP PRACTICE

Requirements for Membership are as follows: a partnership, corporation, company, or other business that is engaged in the independent practice of urology and is located in the boundaries of the United States of America.

There are two membership categories:

1. Standard members are independent urology groups of **five (5) or more** urologists and/or urogynecologists
2. Associate members are independent urology groups of **less than five (5)** urologists and/or urogynecologists

SUBMITTER INFORMATION

First Name: _____ **Last Name:** _____

Phone: _____ **Email:** _____

PRACTICE INFORMATION

Name of Corporation (the legal name of your group practice):

_____

Address: _____

City: _____ **State:**_____ **Zip:** _____**Country:** _____

Phone: _____ **Fax:** _____

Corporate Website Address: _____

Current Number of: **Urologists:** _____ **Urogynecologists:** _____ **Offices in Your Group:** _____

Is Your Practice Multispecialty? ❑ Yes ❑ No **Is Your Practice Academically Affiliated?** ❑ Yes ❑ No

Number of Physician Assistants: _____ **Number of Nurse Practitioners:**_____

WHICH OF THE FOLLOWING SERVICES DOES YOUR PRACTICE PROVIDE

❑ In office dispensing of drugs ❑ Laboratory ❑ Pathology ❑ Surgery Center

Imaging: ❑ CT ❑ MRI ❑ X-Ray

Radiation: ❑ Cyberknife ❑ IMRT

POTENTIAL EXPANSION TO INCLUDE

Number of Additional: **Urologists:** _____ **Urogynecologists:** _____ **Offices in Your Group:** _____

Expected Date of Completion:_____

REQUIRED INFORMATION: Collect the following individual demographics for Urologists, Urogynecologists, COOs, CEOs and Practice Administrators. **Please include a member census spreadsheet containing the below fields with your application.**

PLEASE NOTE: Membership will not be approved until a full listing of all urologists and urogynecologists is collected.

First Name: _____ **Last Name:** _____

Degree(s) Designation: _____ **Date of Birth:** _____ **Gender:** ❑ Male ❑ Female

Role:_____ **Professional Title:** _____

Email:_____

Use Corporate Address? ❑ Yes ❑ No

Company/Practice Name: _____

Address: _____

City: _____ **State:**_____ **Zip:** _____**Country:** _____

Direct Phone: _____

Please forward your application, along with the census information from the LUGPA membership census spreadsheet to:

LUGPA Membership Department
Two Woodfield Lake
1100 E. Woodfield Road, Suite 350
Schaumburg, IL 60173
Phone: (847) 517-7225 Fax: (847) 517-7229 Email: info@lugpa.org