# 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:** US

**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 ☐ Pathology ☐ Laboratory ☐ Pharmacy ☐ Surgery Center ☐ Urodynamics

☐ Chemotherapy ☐ Radiation Center ☐ Physical Therapy ☐ Mona Lisa Touch ☐ Research Capabilities

**Imaging:** ☐ CT ☐ MRI ☐ X-Ray ☐ Dexascan ☐ Abdominal/Renal Ultrasound

☐ Scrotal Ultrasound ☐ Transrectal Ultrasound

**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, Practice Administrators and physician extenders. **Please send a Member Census Spreadsheet, which can be found as an attachment, with your application to mcox@lugpa.org.** To see attachments, click

**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:** Other **Professional Title:** _____

**Email:** _____

**Use Corporate Address?** ❑ Yes ❑ No

**Company/Practice Name:** _____

**Address:** _____

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

**Direct Phone:** _____

*Questions regarding membership or this form? Contact Morgan Cox at **mcox@lugpa.org** or **(312) 794-7787.***

**Click to Submit Form to LUGPA HQ**

**If you prefer not to submit your application electronically, you can mail your application, along with the census information from the LUGPA membership census spreadsheet to:**

LUGPA Headquarters
875 N. Michigan Avenue, Suite 3100
Chicago, IL 60611
Phone: (312) 794-7790 Email: info@lugpa.org