Associate Membership Application for Indiana Orthopaedic Society

Applicant must be recommended by his/her Orthopaedic Surgeon who is member in good standing of IOS.

Check One: ☐ PA-C ☐ NP

PLEASE PRINT

Date:________________

Name: ____

Spouse/Life Partner: ____

Home Address:____

City/State/Zip/County: ____

Home Phone: ______________________________E-Mail: ______________________________

Office Address:____

City/State/Zip:____

Office Phone: ______________________________Office Fax: ______________________________

County where office is located: ____

Name of facility where you trained:____

Date of Graduation/Certification:____

Name of physician sponsor:____

Check all that apply:

☐ TKR ☐ THR ☐ Trauma ☐ Spine ☐ General Ortho ☐ Tumor ☐ Upper Extremity

☐ Other:____

Associate Membership Application Form must be completed and mailed to:

Indiana Orthopaedic Society • P.O. Box 68755 • Indianapolis, IN 46268-0755