Membership Application for Indiana Orthopaedic Society

Applicants must be Board Eligible or Board Certified by the ABOS - Osteopathic Boards, Physician Assistant Boards, Nurse Practitioner Boards

PLEASE PRINT

Date: _____

Specialty: _____ Office Contact: _____

Name: _____

Spouse/Life Partner: _____

Office Address: _____

City/State/Zip/County: _____

Office Phone: _____ Office Fax: _____

Home Address: _____

City/State/Zip: _____

Home Phone: _____ E-Mail: _____

Medical School: _____

Date of Graduation: _____

Residency Program and Location: _____

Date: _____

Fellowship Training: _____

Type: _____ Location: _____

Date: _____

Date of Licensure in Indiana: _____

Date of Certification by American Board of Orthopaedic Surgery: _____

Date of Certification by Osteopathic Board: _____

Date of Certification by PA Board: _____

Date of Certification by NP Board: _____

Sponsor Names: IOS Members in good standing

Name: _____

Name: _____

Continue to next page: Enter applicant's name, as nominee, and check one position. Then forward the page (Membership Sponsor Form) to your sponsors for completion.

Membership Sponsor Form

Name of Nominee: _____

Check One: ☐ MD ☐ DO ☐ Physician Assistant Certified ☐ Nurse Practitioner Certified

TO BE COMPLETED BY SPONSOR

Please Complete Promptly and Mail This Page to Address Below.

PLEASE PRINT

Date: _____

Sponsor's Name: _____

Address: _____

City/State/Zip _____

Phone/Fax: _____

1. How long have you known the nominee? # year(s)_____ # month(s) _____

2. Is the nominee associated with you in practice?

_____ Yes # year(s) _____ # month(s)_____

_____ No

3. Please comment on any other specific areas that will be helpful to the Membership Committee.

_____

_____

_____

_____

_____

_____

_____

4. Have you personally contacted this person regarding membership nomination?

_____YES _____NO

If no, please do so before submitting his/her name, this avoids any embarrassment to you and IOS.

As sponsor, I agree to act as mentor to this member candidate and will agree to maintain contact with him/her once membership is approved.

Sponsor's Name: _____

Sponsor's Signature: **X**_____

Office Phone: _____ Date: _____

Membership Application and Membership Sponsor Form must be completed and mailed to:

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