2020
ASSOCIATE MEMBERSHIP APPLICATION
FOR
INDIANA ORTHOPAEDIC SOCIETY

____PA-C ____NP

Please Print:
Date: ________________

Name: ______________________________ Spouse/Partner: ___________________

Home Address: ____

Home Phone: _____________________ E-Mail: ____________________________

Office Address: ____

Office Phone: ____

Office Fax: _______________________________

County were office is located: ________________

Name of facility where you trained: ____

Date of Graduation/Certification: ________________________

Name of physician sponsor: _____________________________

Circle all that apply:
Physician Specialty: TKR, THR, Trauma, Spine, General Ortho, Tumor, Upper Extremity, Other _________________

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

Mail or Email To:
Kellye Mitros
Interim Executive Director
Indiana Orthopaedic Society
P.O. Box 1221
South Bend, Indiana 46624
iosocietydirector@gmail.com
Tel: (574) 360-4154