(Sample) PMR Society

Address
Phone

APPLICATION FOR MEMBERSHIP

Complete in full and return to the above address with your dues:

Circle Membership Classification Applied for:

ACTIVE (Specify Amount) ASSOICATE: (NON PHYSIATRIST (Specify Amount)

Full Name: _____ Board Specialty: _____
Medical School Attended and Date Graduated: _____
Office Address: _____
Office Phone: _____ FX: _____
Email: _____
Website: _____

Circle **Membership Status: YES NO Mandatory TMA and/or County Society Membership**

Membership of what County Medical Society: _____

Type of Practice:
- Private Practice (office based) _____
- Private Practice (hospital based) _____
- Full Time Faculty _____
- Veteran's Hospital _____
- Military _____
- Resident _____
- Other: _____

Therapies Legend:
(This will be kept as part of your membership record and you can update it yearly.)

Note the letter listed below of all therapies you offer in your practice: _____

A. Acupuncture
B. Botox Therapies – Adult _____ Pediatric
C. Causal Epidural Blocks
D. Corticosteroid Injections
E. Electrotherapies
F. Electrodiagnostic Medicine – EMG/NCV
G. Flouscopic Guided Spinal Procedures
H. Diagnostic Musculoskeletal Ultrasound
I. ESI
J. Neural Therapy
K. Prolotherapy
L. SCI

Years Training (will be) completed: _____ Program Director: _____
Year of Board Certification: _____
If not board certified, please summarize your training or experience in PM&R on a separate sheet of paper.
Nominated for membership by the following Society Members:

1)_____
Name Phone Number

2) _____
Name Phone Number