



Application for Membership

Prefix _____ Name _____ Suffix _____ Gender M or F

Degree(s) _____ Preferred Mailing Address Office Home Preferred Directory Address Office Home

Office Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Home Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Email _____ Website _____ Date of Birth _____

Are you a member of the AUA? Yes No If yes, what type? Active Affiliate

Membership Categories

- ACTIVE MEMBERSHIP: \$150.00 USD (Annual Dues / Application Fee)**
Must be a member in good standing of the American Urological Association. Must have acceptably completed an accredited urologic training program or its equivalent in a foreign country; or must have acceptably completed an accredited PhD in an allied basic science field and be currently active in urologic research. Active members have voting privileges.
- AFFILIATE MEMBERSHIP: \$150.00 USD (Annual Dues / Application Fee)**
Must be a physician in a related field of medicine and science who cannot qualify for Active Membership, or a non-physician who, by professional or personal accomplishments, has contributed significantly to medicine in general or the specialty of urology in general. Affiliate members may not vote.
- CANDIDATE MEMBERSHIP: Fees Waived GRADUATION YEAR: _____**
Must have graduated from an accredited medical school with receipt of Doctor of Medicine degree or an equivalent degree. Must be enrolled in a resident or fellowship program credentialed by the Accreditation Council for Graduate Medical Education (ACGME) or such similar body in a foreign country or post-doctoral fellows having completed an accredited PhD in an allied basic science field and active in urologic research. Candidate members may not vote.

Payment Information

- Check (Payable to Society of Women in Urology)
- Credit Card (Circle): Visa MasterCard
Card Number _____
CVV # _____
Expiration Date _____
Name on Card (Printed) _____
Cardholder's Signature _____

Please forward application and fee / dues to:

Society of Women in Urology
Membership Department
Two Woodfield Lake
1100 East Woodfield Road, Suite 350
Schaumburg, IL 60173
Phone: (847) 517-7225 • Fax: (847) 517-7229
Email: info@swiu.org

Signature of Applicant _____ Date _____