



Application for Membership

Two Woodfield Lake • 1100 East Woodfield Road, Suite 350 • Schaumburg, IL 60173

Phone: (847) 517-8712 • Fax: (847) 517-7229 • Email: info@pelvicpain.org

Membership Categories:

- PHYSICIAN HEALTH CARE PROVIDER: \$250 (APPLICATION FEE/ANNUAL DUES)**
- NON-PHYSICIAN HEALTH CARE PROVIDER: \$125 (APPLICATION FEE/ANNUAL DUES)**

Name _____ **Sex** M or F

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

Institution _____

Office Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Home Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Telephone _____ Fax _____

Web page URL _____

Email _____ **Date of Birth** _____

Address Listings:

- Yes, please include me in the membership directory.
- No, do not include me in the membership directory.

Include my office information in the public "Find a Provider" section on the IPPS website:

- Yes No

IPPS Discussion Listserv:

- Please check here to join the IPPS discussion list. By selecting this option, your email address will be added to the Listserv system.

If accepted for membership, I hereby agree to abide by the Constitution and Bylaws of the International Pelvic Pain Society.

Signature of Applicant _____ **Date** _____



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Payment Options:

Check (Payable to the International Pelvic Pain Society)

Credit Card (Circle): Visa MasterCard American Express

Card Number _____

CW # _____

Expiration Date _____

Cardholder's Signature _____

Please forward application and supporting documents to:

International Pelvic Pain Society

Membership Department

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