



# MEMBERSHIP APPLICATION

## PLEASE TELL US ABOUT YOUR UROLOGY GROUP PRACTICE

Requirements for Membership are as follows: a partnership, corporation, company, or other business that is engaged in the independent practice of urology and is located in the United States of America, consisting of 50 states, a federal district (DC), and five major unincorporated territories.

There are two membership categories:

1. Standard members are independent urology groups of **five (5) or more** urologists and/or urogynecologists
2. Associate members are independent urology groups of **less than five (5)** urologists and/or urogynecologists

## SUBMITTER INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## PRACTICE INFORMATION

Name of Corporation (the legal name of your group practice):

\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Corporate Website Address: \_\_\_\_\_

Current Number of: Urologists: \_\_\_\_\_ Urogynecologists: \_\_\_\_\_ Offices in Your Group: \_\_\_\_\_

Is Your Practice Multispecialty?  Yes  No Is Your Practice Academically Affiliated?  Yes  No

Number of Physician Assistants: \_\_\_\_\_ Number of Nurse Practitioners: \_\_\_\_\_

## WHICH OF THE FOLLOWING SERVICES DOES YOUR PRACTICE PROVIDE

In-Office Dispensing  Pathology Laboratory Pharmacy Surgery Center Urodynamics  
Chemotherapy  Radiation Center Physical Therapy Mona Lisa Touch Research Capabilities

Imaging: CT MRI X-Ray Dexascan Abdominal/Renal Ultrasound  
Scrotal Ultrasound Transrectal Ultrasound

Radiation: Cyberknife IMRT

## POTENTIAL EXPANSION TO INCLUDE

Number of Additional: Urologists: \_\_\_\_\_ Urogynecologists: \_\_\_\_\_ Offices in Your Group: \_\_\_\_\_

Expected Date of Completion: \_\_\_\_\_

**REQUIRED INFORMATION:** Collect the following individual demographics for Urologists, Urogynecologists, COOs, CEOs, Practice Administrators and physician extenders. **Please send a [Member Census Spreadsheet](#), which can be found as an attachment, with your application to [lwilliams@lugpa.org](mailto:lwilliams@lugpa.org).**

**PLEASE NOTE:** Membership will not be approved until a full listing of all urologists and urogynecologists is collected.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Degree(s) Designation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Role: \_\_\_\_\_ Professional Title: \_\_\_\_\_

Email: \_\_\_\_\_

Use Corporate Address?  Yes  No

Company/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Direct Phone: \_\_\_\_\_

Questions regarding membership or this form? Contact Laurie Oken at [loken@lugpa.org](mailto:loken@lugpa.org).

If you prefer not to submit your application electronically, you can mail your application, along with the census information from the LUGPA membership census spreadsheet to:

LUGPA Headquarters  
875 N. Michigan Avenue, Suite 3100  
Chicago, IL 60611  
Phone: (312) 794-7790 Email: [info@lugpa.org](mailto:info@lugpa.org)