



**NEW ENGLAND SECTION
OF THE AMERICAN UROLOGICAL ASSOCIATION, INC.**

ALLIED MEMBERSHIP APPLICATION

New England Section Allied Membership is available to non-physician professionals, including nurses and nurse practitioners, technicians, physician assistants and medical assistants, specializing or concentrating in urology and serving in a health care setting.

Contact Information			
FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX/CREDENTIAL
Office Address:			
OFFICE/INSTITUTION	ADDRESS	CITY /STATE /POSTAL CODE	
Home Address:			
ADDRESS	CITY/STATE /POSTAL CODE		
Preferred address for NEAUA correspondence: _ Office _ Home			
OFFICE TELEPHONE	HOME TELEPHONE	OFFICE FAX	
E-MAIL ADDRESS	WEB SITE		
GENDER _ M _ F			
Date of Birth			
DAY	MONTH	YEAR	

Education (complete all applicable fields)		
UNIVERSITY/COLLEGE	DEGREE	DATE
GRADUATE SCHOOL	DEGREE	DATE
MEDICAL SCHOOL	DEGREE	DATE
OTHER TRAINING PROGRAM	DEGREE	DATE
OTHER TRAINING PROGRAM	DEGREE	DATE

Professional Qualifications (complete all applicable fields)

CERTIFICATION

MOST RECENT DATE OF CERTIFICATION (MONTH/YEAR)

CERTIFICATION

MOST RECENT DATE OF CERTIFICATION (MONTH/YEAR)

MEDICAL LICENSE

LICENSE NUMBER

STATE

MEDICAL LICENSE

LICENSE NUMBER

STATE

CLINICAL PRACTICE

STAFF APPOINTMENTS/YEARS

STAFF APPOINTMENTS/YEARS

OTHER

Percentage of professional time devoted to urology field _____ %

Society and Referral Information

Please provide one or more local, state, and national societies in which you are a member in good standing.

Were you referred by an NEUA member to join the Section? Yes No

If yes, please provide the name of the member that referred you _____

Medical Background

If you answer yes to any of the statements below, please provide a letter of explanation with your application.

Has your medical certification/license ever been suspended, terminated, limited in any way or reduced in scope? Yes No

Have you ever had hospital staff privileges denied, reduced in scope or rescinded for cause? Yes No

Have you ever had disciplinary action taken against you at any time by a medical society, academic institution or governmental agency? Yes No

Have you ever been convicted of or pleaded guilty to a felony or other serious crime? Yes No

Please ensure the materials listed below are included with your application:

One (1) letter of endorsement from an NEUA voting member (Active or Senior)

A copy of your curriculum vitae or résumé

Copy of applicable medical license(s) and/or certification(s)

Written evidence from certifying Board (if applicable)

Verification letter from direct supervisor confirming you have at least one (1) year experience in the field of urology [or at least three (3) years of in-service training for technicians] and have devoted at least 50% of your professional time to urologic care

Application Submission

I, _____, hereby certify that all information recorded on this application and any attached document is accurate and supports my qualifications for membership in the New England Section of the American Urological Association for which I now apply.

I hereby agree that the New England Section of the American Urological Association may verify any data provided with this application. If elected, I agree to conform to all applicable policies and membership requirements of the NEUA and uphold its Code of Ethics.

Signature _____ Date _____