



**ISUCRS**  
INTERNATIONAL SOCIETY OF UNIVERSITY  
COLON AND RECTAL SURGEONS

ISUCRS Membership Services  
11300 W Olympic Blvd # 600  
Los Angeles CA 90064  
Phone: 310-909-0107 Ext. 110  
Fax: 310-437-0585  
Email: membership@isucrs.org  
Web Site: www.isucrs.org

**APPLICATION FOR MEMBERSHIP**

Application Date: \_\_\_\_\_

PLEASE TYPE OR PRINT CLEARLY

**Applicant's Name in Full:**

\_\_\_\_\_  
(Last/Family Name) (First/Given Name) (Middle Name or Initial)  
 MD  DO  PhD  Prof  Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

**Please check preferred mailing address:**

**Professional Address:**

\_\_\_\_\_  
(Title/Dept)  
\_\_\_\_\_  
(Organization)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State/Province) (Zip/Postal Code) (Country)  
\_\_\_\_\_  
(Telephone Number) (Fax Number) (E-Mail Address)

**Residence Address:**

\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State/Province) (Zip/Postal Code) (Country)  
\_\_\_\_\_  
(Telephone Number) (E-Mail Address)

**Membership in Medical/ Surgical Organizations (Please include dates):**

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**Medical School/ University Affiliations:**

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**Teaching Positions:**

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(Title) (Medical School) (Dates From/To)

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(Title) (Medical School) (Dates From/To)

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(Title) (Medical School) (Dates From/To)

**Research Investigation:**

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**Hospital Appointments:**

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**Published Contributions to Medical Literature (Use separate sheet if necessary):**

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**Names and Addresses of Sponsors (ISUCRS ACTIVE members who have agreed to endorse you for membership):**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  
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**Please write EXACTLY how you would like your name to appear on your membership certificate:  
(Example: John A. Smith MD)**

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- I have included payment of the **Initiation Fee** (\$50 USD one-time, non-refundable charge).
- I am applying for **Active1 Membership** (\$150 USD annually) and, upon approval, will be invoiced for first year's dues.
- I am applying for **Active2 Membership** (\$100 USD annually) and, upon approval, will be invoiced for first year's dues.

A check (USD only) is enclosed with this application. Please make checks payable to ISUCRS.

I authorize you to charge my:     VISA             MasterCard

CC Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Amount: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Fees must be paid in US dollars. Arrangement for bank wire transfer payment may be made by contacting ISUCRS office for details.