imda
Indiana Society for Post-Acute and Long-Term Care Medicine

Membership Application

How to apply:

1. **Did you know you can join on our website at: www.inmda.com/online-membership-application/**
2. Otherwise, complete each section of the application in its entirety. Be sure to sign and date the application.
3. Return your completed application with payment to IMDA via mail.
4. Questions? Contact IMDA@IN-PALTC for more information

General Information

Prefix _____ Name (First, Middle, Last, Suffix) _____ _____

Credentials_____ Title _____

Facility _____

Preferred Method of Communication: ❑ E-mail ❑ mail

E-mail Address _____

Office Phone (_____) _____ Home Phone (_____) _____

Fax (_____) _____ Cell Phone (_____) _____

Mailing Address: ❑ Business ❑ Home

Company/Facility (if applicable) _____

Street _____ Apt/Suite_____

City _____State_____Zip_____ Country _____

Specialty

Primary Specialty: _____ Certified ❑ Yes ❑ No If yes, how many years?_____

Secondary Specialty: _____ Certified ❑ Yes ❑ No If yes, how many years? _____

Sub Specialty: _____ Certified ❑ Yes ❑ No If yes, how many years?_____

Check All That Apply

I serve as a: ❑ Physician ❑ Advanced Practice Nurse ❑ Provider in Training ❑ Nurse

❑ Pharmacist ❑ Social Worker ❑ Therapist ❑ Administrator ❑ Physicians Assistant

❑ Industry/Corporate Professional ❑ Other _____

I have am a Certified Medical Director (CMD) ❑ Yes ❑ No I have served as a Medical Director for _____ years.

How did you learn about IMDA? _____

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Name: _____

Membership Dues

	Cost
❑ **Membership**	**$75.00**
❑ **Providers in Training**	**Free**

Payment Summary

Total Amount Enclosed: $ 75 (Please submit full amount. Your application cannot be processed without payment.)

Please mail check to:
IMDA
P.O. Box 34067
Indianapolis, IN 46234

Signature and Date

Signature _____ Date_____