THE INDIANA SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

Membership Application

How to apply:

1. Complete each section of the application in its entirety. Be sure to sign and date the application.
2. Return your completed application with payment to IMDA, P.O. Box 34067, Indianapolis, IN 46234.
3. **Did you know you can join on our website? www.inmda.com/online-membership-application/**
4. Questions? Contact IMDA@IN-PALTC.com for more information.

General Information

Prefix ___________ Name (First, Middle, Last, Suffix) ____ __________

Credentials______________________________ Title ____

Facility ____

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 MD/DO ❑ Advanced Practice Nurse NP/CNS ❑ Physicians Assistant ❑ Nurse RN/LPN

❑ Pharmacist ❑ Social Worker ❑ Therapist OTR/PT/SLP/COTA/PTA ❑ Administrator ED/DON/ADON

❑ Industry/Corporate Professional ❑ Fellow ❑Resident ❑Intern ❑Student

❑Other ______________________

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

How did you learn about IMDA? ____

Name: ____

Membership Dues

	Cost
❑ **New Membership**	**$75.00**
❑ **Renewal 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__________________