

MEMBERSHIP APPLICATION

Complete Only One Section Below

Individual Membership

Individual Full Name _____ MD
 Job Title _____ DO
 Organization Name _____ PA
 Address _____ NP
 _____ RN
 _____ _____
 City _____ State _____ Zip _____
 Country _____
 Phone _____ Fax _____
 Email Address _____

(required to access members-only)

Individual Membership Dues - \$175
(skip to Payment section below)

Clinic Membership

Organization Name _____
 Main Organization Address _____

 City _____ State _____ Zip _____
 Country _____
 Main Phone _____ Fax _____
 Organization Website _____
 Number of Locations 1-2 Clinics (\$325)
 (Please list on back of 3-4 Clinics (\$475)
 this application sheet) More than 5 Clinics (\$650)

Please complete the appropriate section below to name individuals who will receive this membership's benefits.

Clinic Membership Benefits Recipients

If you have chosen a Clinic Membership above, please provide names of individuals who will receive benefits through the membership. All mailings will go to main organization address.

- 1-2 Clinics (up to 5 people) 3-4 Clinics (up to 7 people) 5+ Clinics (up to 10 people)

1. Main Contact: _____ Email: _____
2. Name _____ Email: _____
3. Name _____ Email: _____
4. Name _____ Email: _____
5. Name _____ Email: _____
6. Name _____ Email: _____
7. Name _____ Email: _____
8. Name _____ Email: _____
9. Name _____ Email: _____
10. Name _____ Email: _____

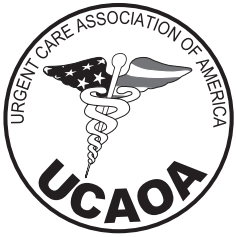
Check here if you would like to provide alternate addresses for some individuals. Note clinic number from back by individual name.

Payment

Credit Card (Visa or Mastercard only) Check enclosed
 CC# _____ Exp. _____
 Name on card _____

Dues-paying members are eligible for print copies of the *Journal of Urgent Care Medicine (JUCM)*. A portion of your annual dues (\$15) is allocated for a one year subscription to *JUCM* not deductible from UCAOA membership dues. All members also receive free online access to *JUCM* archive copies.

Fax to 630-836-8518 or Mail to **UCAOA** Attn: Membership, 4320 Winfield Road, Suite 200, Warrenville, IL 60555
(Please call 877-698-2262 to confirm fax receipt.)



CLINIC LOCATIONS

Provide "Clinic Name" only if different than "Main Organization" name.
If more than 10 Clinics, attach additional sheets as needed.

#1

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#6

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#2

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#7

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#3

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#8

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#4

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#9

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#5

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

#10

Clinic Name _____
Address _____

City _____ State _____ Zip _____
Phone _____ Fax _____

Please provide information for all available Clinics in order to be listed on
"Find an Urgent Care Center" listing on www.UCAOA.org.