IANS
The International Anal Neoplasia Society

APPLICATION FOR MEMBERSHIP

NAME _____
First Middle Last

UNIVERSITY or COLLEGE_____DEGREE_____ YEAR GRADUATED _____

NURSING /ADVANCED CLINICAL SCHOOL_____ DEGREE_____ YEAR GRADUATED _____

MEDICAL SCHOOL_____DEGREE_____YEAR GRADUATED _____

RESIDENCY TRAINING (Specialty and institution)_____ DATE _____

RESIDENTS Current program year (e.g. PGY2)_____ expected date of graduation DATE _____

FELLOWSHP (if applicable)_____ DATE _____

CERTIFICATION_____ DATE_____

Please complete the following sections carefully to assist the membership committee in reviewing your application.

ANOSCOPY TRAINING:

_____

_____

_____

_____

High Resolution Anoscopy: (date) _____ INSTITUTION _____

		☐	☐
LICENSURE:	Has your license to practice ever been revoked?	☐Yes	☐No
	Have you ever been denied a license to practice?	☐Yes	☐ No
	Have you ever voluntarily surrendered your license?	☐Yes	☐ No
	Have you ever been the subject of any professional misconduct proceedings or are they pending? .	☐Yes	☐ No
	Have any sanctions or restrictions been imposed by any licensing authority?	☐Yes	☐ No

If yes to any of the above, please explain: _____

HAVE YOU EVER BEEN CONVICTED OF COMMITTING AN ACT CONSTITUTING A CRIME OR FELONY?

☐ Yes ☐ No *(NOTE: This excludes minor traffic violations)*

The following is for informational purposes only and is not required for membership.

PRACTICE SPECIALTY _____

PUBLICATIONS: _____

_____

_____

SOCIETY MEMBERSHIPS: _____

_____

Submit your application with the dues to join IANS. Your membership period a calendar year from the date approved.

Active Membership Dues: $300.00 Advanced Practice Clinician: $200 Resident and Fellow Dues: $100.00

I hereby apply for ACTIVE ☐ ADVANCED PRACTICE CLINICIAN ☐ RESIDENT/ Fellow ☐

I agree to be bound by the bylaws of the organization that may be found at iansoc.org

APPLICANT SIGNATURE: _____ DATE: _____

RESIDENTIAL: _____

ADDRESS _____

City State Zip Code

PROFESSIONAL: _____

ADDRESS _____

City State Zip Code

TELEPHONE: _____ FAX: _____ EMAIL: _____

☐

Mail completed form to:

IANS
P.O. Box 1543
Leesburg, Virginia 20177
iansociety@gmail.com
www.iansoc.org

PAYMENT INFORMATION (PLEASE COMPLETE)

Amount enclosed/charged $_____

Payment made by check (payable to IANS) or by credit card: Visa MasterCard American Express

Card Account number:_____Expiration Date: _____CVV3_____

Name on Card: _____Signature X_____

Address if different from address shown above. _____

_____

_____