



Society of Genitourinary  
Reconstructive Surgeons

# Membership Application

**Applicant Submission Checklist:**

- Completed Application and Annual Dues payment
- Curriculum Vitae, abbreviated form, preferably the NIH format
- Surgical Case Log, 12-month period (to include all prosthetics, incontinence, and urethroplasty). Surgical Log must include: patients initials or hospital identification number; date of procedure; and surgical procedure completed. 6-month period, case log is acceptable for Fellows.
- One Sponsor Letter from an Active Member of the Society. Your sponsor may mail, fax, or email their letter directly to the GURS Headquarters.

**Membership:**

**ACTIVE MEMBERSHIP (\$100.00 USD Annual Dues):** Active members are defined as surgeons or others who must demonstrate significant interest in the field of genitourinary reconstructive surgery. Annual Dues for **International Members** are based on the World Bank Classification. Please review the [GURS International World Bank Classification](#) in order to determine your Dues rate.

Prefix: \_\_\_\_\_ Name: \_\_\_\_\_ Suffix: \_\_\_\_\_ Credential(s): \_\_\_\_\_

Title: \_\_\_\_\_ Institution/Organization: \_\_\_\_\_

Medical License:  Yes  No

State/Country of Licensure: \_\_\_\_\_

Are you Board Certified?  Yes  No

Hospital Affiliations: \_\_\_\_\_

Specialty: \_\_\_\_\_

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

Gender:  M or  F

Preferred Mailing Address ( Home or  Work): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Mailing Address ( Home or  Work): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Payment Information:** *Per PCI compliance, Credit Card Payments must be faxed in to our secure fax: (410) 689-3825.*

Check: Society of Genitourinary Reconstructive Surgeons    Credit Card:    Visa    MasterCard    American Express

Annual Dues:    A: \$100    B: \$75    C: \$50 (To confirm your dues rate, please refer to the [World Bank Classification](#))    Credit

Card Number: \_\_\_\_\_    Expiration Date: \_\_\_\_\_    CVV: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_    Date: \_\_\_\_\_

Submit Application Packet to Society of Genitourinary Reconstructive Surgeons:

1000 Corporate Boulevard Linthicum, MD 21090 Fax: (410) 689-3825

If you have questions, contact GURS at (410) 689-3950 or [info@societygurs.org](mailto:info@societygurs.org)

Office Use Only:

Date Received:	Date Approved:	Order Number:	ID Number:
----------------	----------------	---------------	------------

Visit GURS website at [www.SocietyGURS.org](http://www.SocietyGURS.org)