



**PHYSICIAN MEMBERSHIP RENEWAL FORM**

**PHYSICIAN MEMBERSHIP RENEWAL (ANNUAL)**      **Renewal Date:** \_\_\_\_\_

**\$295.00** includes one page physician listing in the Referrals section of our Web site at [www.pituitary.org](http://www.pituitary.org), as well as an individual listing in the referrals section of the Pituitary Patient Resource Guide.

SELECT YOUR LISTING CATEGORY

- Cardiologist       Dermatologist
- Neurosurgeon       OB/GYN
- Endocrinologist       Gastroenterologist
- Ophthalmologist       Pathologist
- Psychiatrist       Psychologist
- Radiologist       Rheumatologist
- Skull Base       Surgeon

MEMBERSHIP PAYMENT INFORMATION

- Payment Information:       Invoice Required
- Visa / MC / Amex / Discover
- Check Enclosed
- Cardholder: \_\_\_\_\_
- Card #: \_\_\_\_\_
- Expiration: \_\_\_\_\_
- Signature: \_\_\_\_\_

**Our website at [www.pituitary.org](http://www.pituitary.org) features an Ask the Experts** section where pituitary patients can post disorder related questions. While it is made clear that this forum is in no way a substitution for consultation with their physician(s), our Ask The Experts is a valuable resource for patients seeking added information from those more familiar with their condition than perhaps their General Practitioner. We are always interested in adding qualified physicians to our list of those willing to help answer some of these questions. Please let us know if you would like to participate.

Yes, I would like to participate in the Ask The Experts online program.      Email: see UPDATED LISTING INFORMATION

UPDATED LISTING INFORMATION

Your name as it should appear in your listing: \_\_\_\_\_

Division/Department (if applicable): \_\_\_\_\_

Contact person for this listing: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Post Code: \_\_\_\_\_

Country: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

UPDATED INTERNET REFERRAL INFO (Please send us your photo with this form for inclusion in your listing.)

Title: \_\_\_\_\_

Clinic/Hospital: \_\_\_\_\_

Medical School: \_\_\_\_\_

Internship: \_\_\_\_\_

Residency: \_\_\_\_\_

Fellowship: \_\_\_\_\_

Board Certification: \_\_\_\_\_

Clinical Interests: \_\_\_\_\_