

I.A.M.R.A.
INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES
MEMBERSHIP APPLICATION FORM
PLEASE TYPE OR PRINT

Please complete the information below:

Name of Organization:

Department or Division (if appropriate):

Street Address or Post Office Box/Contact:

City:

State or Province:

Country:

Zip or Postal Code:

Name of Chief Executive Officer (CEO):

Title of CEO:

Phone:

Fax:

Email:

Organization Web Site:

Person to whom all communications from the IAMRA Secretariat should be sent (if different from above):

Name:

Title:

Phone:

Fax:

Email:

If applying for **Full Membership**, please provide in the space below a general description of the following:

1. The legal authority (provincial, federal or state laws) by which your organization has received its regulatory powers.
2. A description of your organizational structure (e.g. government agency or self-regulatory body, etc).
3. Which regulatory services are provided (licensure, complaints, discipline, education, specialist certification, continuing competence, physician health, etc.).
4. To what staff or office should information on disciplinary actions be sent.

If applying for **Associate Membership**, please provide in the space below information about your organization that is pertinent to medical regulation.

Signature of CEO or President (*required*)

PLEASE RETURN APPLICATION FORM WITH ANNUAL DUES (SEE DUES STRUCTURE) TO:

IAMRA Secretariat
PO Box 619850
Dallas, Texas 75261-9850
USA