



Membership Application

Date: _____

Name: _____

Title: _____

Hospital/Group/System: _____

Website: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone: _____

Fax: _____ Cell: _____

Cell Phone will only be published to ISPR Members

Service Area of Your Organization: _____

Description of Your Organization: _____

Residency Programs in Your Organization: _____

What % of time is devoted to Recruitment? _____

How many years of experience do you have in Recruitment? _____

What is your Highest Educational Degree? _____

Do you charge a fee to recruit physicians? If yes, please explain structure: _____

Please email or fax application to:

Michelle Thompson

Fax: 312.942.7378

Email: chel224@gmail.com

Please mail your \$100 Annual Dues to:

ISPR

P.O. Box 2163

Northlake, IL 60164

Please Note: An invoice will be emailed to you for your records.