

**REQUEST FOR DUES EXEMPT STATUS  
OR  
REFUND OF MEMBERSHIP DUES**



The following information must be filled out and submitted by the physician member. Please print or type information, except where a signature is needed. All requests for dues exempt status, waiver or refund of dues will be submitted to the ISMS Board of Trustees for consideration and approval.

Member Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_  
Date of Submission: \_\_\_\_\_

**Request for Dues Exempt Status (check as appropriate):**

**RETIRED**

*Fully retired and does not assume compensated salary.*

Effective for membership year beginning \_\_\_\_\_

**WAIVER FOR CAUSE**

*Provided for only one year; if wished to be extended for another year, request must be resubmitted.*

Effective for membership year beginning \_\_\_\_\_

**Request for Refund of Dues:**

**REFUND OF DUES**

*No membership dues will be refunded in whole or in part following the January 1<sup>st</sup> commencement of each membership year. This policy may be waived by action of the ISMS Board of Trustees based upon special circumstances, such as a member's death.*

Reason for waiver (circle one or more):

- 1) Physician is in ill health
- 2) Financial hardship
- 3) Missionary work

Reason for refund:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please return completed form to:**

Kris Johnson, Membership Services Department  
Illinois State Medical Society  
Suite 700, 20 North Michigan Avenue, Chicago, IL 60602  
Fax: (312) 782-2023