



## DIRECTORY ORDER FORM

Please send \_\_\_\_\_ copies of the **2010/2011 ISMA Membership Directory** to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Member Name:** \_\_\_\_\_  
(if ordering at member rate, indicate name of physician member)

Enclosed is my check for: \_\_\_\_\_

ISMA Members:                    **\$35 each**

Non-members/hospitals/  
other organizations:            **\$75 each**

Mail order form and check to:

Indiana State Medical Association  
Attn: Membership Dept.  
322 Canal Walk  
Indianapolis, IN 46202-3268