



Request for Dues Waiver Due to Retirement or Disability

Name: _____ Date: _____

ASA Member number: _____

Phone: _____

Active Member Affiliate Member Anesthesiologist Assistant Member

Are you planning to relocate and want to change your address?

Yes No

If yes, please indicate your change of address/phone and/or other contact information:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Email: _____

Reason for Request:

Retirement as of _____

Disability: Permanent Disability Temporary Disability (Check one.)

Email completed form to:
Texas Society of Anesthesiologists
info@tsa.org

Or fax to:
Attn: Membership
(512) 370-1655

Applications are processed on the 15th of each month.