

## MEMBERSHIP APPLICATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Last First MI*

Preferred Address: (please check one)  Home  Business

Business Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

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

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

E-Mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

### Membership Categories (check category of desired membership)

- Physician - \$150/year
- Nonphysician - \$35/year
  - Nurse
  - Cancer Registrar
  - Pharmacist
  - Other (please specify): \_\_\_\_\_
- Resident/Fellow - Free

### Physician—\$150/year (Please type or print clearly)

Degree:  MD  DO

Specialty: \_\_\_\_\_

Subspecialty: \_\_\_\_\_

Board certifications (List Specialties & Dates): \_\_\_\_\_

Medical school: \_\_\_\_\_ Year graduated: \_\_\_\_\_

Residency completed at: \_\_\_\_\_

Active PA license number: \_\_\_\_\_

Residents'/Fellows' projected training completion date: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Nonphysician—\$35/year** (*Please type or print clearly*)

Hospital/other business affiliation: \_\_\_\_\_

Education/Credentials/Active PA license: \_\_\_\_\_

Professional associations: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Mail completed application to:*  
**Pennsylvania Society of Oncology and Hematology**  
777 East Park Drive  
P.O. Box 8820  
Harrisburg, PA 17105-8820