PSOH | ASCO® State/Regional Affiliate Program

Pennsylvania Society of Oncology & Hematology

Membership Application

Name: _____ Date of Birth _____
Last *First* *MI*

Organization Name:_____

Preferred Address: (*please check one*) ❒ Home ❒ Business

Business Address: _____ Home Address: _____

City: _____ State: _____ Zip: _____ City: _____State: _____ Zip: _____

Phone: _____ Fax: _____ Home Phone: _____

E-Mail Address: _____

Membership Categories (*check category of desired membership)*

❒ Physician - $ 150 per year

❒ Non-physician - $35 per year

❒ Nurse ❒ Cancer Registrar

❒ Pharmacists ❒ Other (*please specify*):_____

❒ Resident – Free ❒ Medical Student – Free

PLEASE COMPLETE ALL FIELDS:

Degree: ❒ MD ❒ DO ❒ ONS ❒ CTR ❒ Other: _____

Specialty: _____Subspecialty: _____

Board certifications (*List Specialties & Dates*): _____

Medical School: _____Year Graduated: _____

Residency completed at: _____

Anticipated Completion Date of Residency Program **[Resident Applicants Only]** _____

Active PA license number: _____

Professional associations: _____

Hospital / other business affiliation: _____

PAYMENT:

___Check: Make Checks Payable to: PA Society of Oncology & Hematology and mail to address below.

Credit Card ❒VISA ❒ MASTERCARD ❒ AMERICAN EXPRESS ❒ DISCOVER

Card Number: _____ EXP. _____/_____ CV2: _____

Name on Card: _____

Signature: _____ Date: _____

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