

**Pennsylvania Society of Oncology & Hematology**

2020 Corporate Membership Application  
(January 1, 2020 – December 31, 2020)

**Company Name:**

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

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

Website: \_\_\_\_\_

**Contact Name:**

Address if different than above: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_

**Exhibit Table Contact Name:**

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

Email: \_\_\_\_\_

**Membership Contribution Levels:**

\$10,000

- Exclusive Networking Event with PSOH Board at Annual Meeting
- First Choice of Table Placement participation for 5 representatives at Annual Meeting
- Work with legislative initiatives
- Opportunity to survey members (based on Board approval)
- Distribution of priority company information on FDA approvals and/or published journal articles to active members (based on Board approval)
- Company logo on the PSOH website and link to company website
- Access to members only side of PSOH website
- Included on email communications to active members

\$ 5,000

- Table Placement Selection prior to general exhibitor assignments, and Participation for 4 representatives at Annual Meeting
- Work with legislative initiatives
- Opportunity to survey members (based on Board approval) – **once per year**
- Distribution of priority company information on FDA approvals and/or published journal articles to active members(based on Board approval) – **three times per year**
- Company logo on the PSOH website
- Access to members only side of PSOH website

**Payment Information:**  Mail check made payable to PSOH

Discover  MasterCard  Visa  American Express

Card # \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

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

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

**Authorized Signature**

**Date**

**Print Name**

**Title**