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

❒ Pharmacists

❒ Cancer Registrar

❒ 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

400 Winding Creek Blvd

Mechanicsburg, PA 17050