APPLICATION FOR MEMBERSHIP

Annual membership dues (January 1–December 31) must accompany application. Mail payment with this form to: Washington State Medical Oncology Society; 1801 Research Boulevard, Suite 400; Rockville, MD 20850.

If you have any questions, please contact the Membership Department at ossmembership@accc-cancer.org.

SELECT THE TYPE OF ANNUAL MEMBERSHIP:

- **Group**: Licensed physicians and allied health professionals including but not limited to registered nurses, nurse practitioners, clinical nurse specialists, pharmacists, physician assistants, administrators, social workers, and office managers in an oncology practice or university. **Dues: Complimentary.**
  - I would like to start a Group! Contact me at the information provided on the next page.

- **Regular**: Licensed physician caring for patients with cancer. **Dues: Complimentary.**

- **Allied Health Professional**: Healthcare staff person including but not limited to registered nurse, nurse practitioner, clinical nurse specialist, pharmacist, physician assistant, administrator, social worker, and office manager. **Dues: Complimentary.**

- **Fellow**: Physician enrolled in subspecialty training program to care for patients with cancer. **Dues: Complimentary.**

- **Retired**: Former physician or allied health professional who is no longer practicing. **Dues: Complimentary.**
COMPLETE YOUR INFORMATION:

SALUTATION (DR., MS., MR., PROF.):___________________________________________________________
FIRST NAME:___________________________ LAST NAME:_________________________________________
SUFFIX:_______________________________ CREDENTIALS:_______________________________________
TITLE:____________________________________________________________________________________
ONCOLOGY SPECIALTY OR AREA OF CONCENTRATION:_____________________________________________
WORK EMAIL:_________________________________________________________________________________
PERSONAL EMAIL:___________________________________________________________________________
INSTITUTION:______________________________________________________________________________
WORK ADDRESS 1:____________________________________________________________________________
WORK ADDRESS 2:____________________________________________________________________________
WORK CITY, STATE, ZIP CODE:__________________________________________________________________
WORK PHONE (+ AREA CODE):_________________________ WORK FAX:_____________________________
HOME ADDRESS 1:____________________________________________________________________________
HOME ADDRESS 2:____________________________________________________________________________
HOME CITY, STATE, ZIP CODE:____________________________________________________________________
PERSONAL PHONE (+ AREA CODE):________________________________

I attest that I meet the qualifications of the membership category for which I am applying, and that I will uphold the
purpose(s) of Washington State Medical Oncology Society.

___________________________________________                                  __________________________
Signature                                         Date

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Oncology State Societies at ACCC
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