ARKANSAS ASSOCIATION OF CANCER PROFESSIONALS
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496
aacp-arkansas.com

APPLICATION FOR MEMBERSHIP

Annual membership dues (January 1–December 31) must accompany application. Mail payment with this form to: Arkansas Association of Cancer Professionals; 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.**

(TURN OVER)

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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 Arkansas Association of Cancer Professionals.

_____ _____
Signature Date