KANSAS SOCIETY OF CLINICAL ONCOLOGY
Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.kasco-kansas.com

APPLICATION FOR MEMBERSHIP

Annual membership dues (January 1–December 31) must accompany application. Mail payment and this form to: Kansas Society of Clinical Oncology; 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:

☐ **Regular:** Licensed physician in practice of oncology/hematology. Includes up to three allied health professionals as Associate members. **Dues: $100.**

☐ **Group:** Physicians of a group practice or university who meet the requirements of Regular membership qualify for Group membership. **Dues: $1000 per practice or university group of up to 25 physicians; $2500 per practice or university group of 26 or more physicians.** Group members may add Associate members at no charge.

☐ **Associate:** Allied healthcare professional who has a demonstrated interest in the care and treatment of cancer patients. **Dues: $50.** *If affiliated with a Group or Regular member, **Dues: Complimentary.**

☐ **Fellow:** Physician enrolled in oncology/hematology training program. **Dues: Complimentary.**

☐ **Retired:** Physician eligible to be a Regular member, but who is retired. **Dues: Complimentary.**

*Regular: On a separate sheet of paper, please list any Associate members included in the Regular membership and their corresponding contact information and submit to the KaSCO Executive Office.

*Group: On a separate sheet of paper, please list additional Regular and/or Associate members included in the Group membership and their corresponding contact information and submit to the KaSCO Executive Office.

FIRST NAME & MIDDLE INITIAL: _____

LAST NAME: _____

DEGREE: _____

TITLE: _____

ORGANIZATION: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY, STATE, ZIP CODE: _____

PHONE AND FAX (+ AREA CODE): _____

EMAIL: _____

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 the Kansas Society of Clinical Oncology.

_____ Signature

_____ Date