MISSOURI ONCOLOGY SOCIETY

Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.mos-missouri.com

APPLICATION FOR MEMBERSHIP

Annual membership dues (January 1–December 31) must accompany application. Mail payment and this form to: Missouri 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:

- ☐ **Regular:** Physician licensed and Board-eligible or Board-certified in internal medicine, pediatrics, surgery, gynecology, hematology, or oncology. **Dues: $100.**
- ☐ **Group:** Four physicians in a healthcare institution (healthcare or academic) or group practice who meet the requirements of Regular membership qualify for Group membership. **Dues: $400 per institution or practice of four physicians.** Additional physicians who meet the requirements may each join as part of the Group. **Dues: $50 each.***
- ☐ **Associate:** Allied health professionals such as registered nurses, nurse practitioners, physician assistants, administrators, social workers, and office managers. If affiliated with Group members or Regular members, **dues are Complimentary. If not, dues are $50 each.**
- ☐ **Fellow:** Physician participating in an approved oncology or hematology subspecialty training program. **Dues: Complimentary.**
- ☐ **Retired:** Physician meeting requirements to be a Regular member but is no longer practicing oncology or hematology. **Dues: Complimentary.**

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

FIRST NAME:_____ LAST NAME:_____

SUFFIX: _____DEGREE:_____

TITLE: _____

INSTITUTION: _____DEPARTMENT:_____

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 Missouri Oncology Society.

_____ _____

Signature Date