TEXAS SOCIETY OF CLINICAL ONCOLOGY
1801 Research Blvd, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496
www.txsco.com

APPLICATION FOR MEMBERSHIP

Complete this application for annual membership (January 1–December 31) and email it to: ossmembership@accc-cancer.org. After you submit the application, the Membership Department will notify you to pay your dues if applicable. You may also apply for membership here or via the QR code to the right.

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: Up to 10 physicians $500 (Small), 11-50 physicians $1,000 (Medium), 51-100 physicians $1,500 (Large), 101+ physicians $2,000 (X-Large). All affiliated allied health professionals are complimentary.**

Select your organization from the list of existing Groups. If your organization is listed, your Group administrator will cover the dues indicated above. If your organization is not listed, select the option to start a new Group or select another type of membership. Fellows should always select the "Fellow" type of membership even if their organization is listed below.

- ☐ The Center for Cancer and Blood Disorders
- ☐ Oncology Consultants, P.A.
- ☐ Texas Oncology
- ☐ I would like to start a new Group! Contact me at the information provided on the next page.

☐ **Regular:** Licensed physician caring for patients with cancer. **Dues: $50.**

☐ **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 the Texas Society of Clinical Oncology.

_____ _____
Signature Date