WISCONSIN ASSOCIATION OF HEMATOLOGY AND ONCOLOGY
1801 Research Blvd, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496
www.waho-wisconsin.com

APPLICATION FOR MEMBERSHIP

Complete this application for annual membership (January 1–December 31) and email it to the Membership Department at ossmembership@accc-cancer.org. Please also direct your questions accordingly. After you submit your 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.

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 $750 (Small), 11-25 physicians $1,500 (Medium), 26+ physicians $2,500 (Large). All affiliated allied health professionals are complimentary.**

Select this option if your organization is listed under "Group" here or at the QR code above. If your organization is listed, your Group administrator will cover the dues indicated above. Fellows should always select the "Fellow" type of membership even if their organization is listed.

If your organization is not listed, select the option to start a new Group or select another type of membership.

☐ Start A New Group! (Be sure to provide your contact information on the next page!)

☐ **Regular:** Licensed physician caring for patients with cancer. **Dues: $100.**

☐ **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. **If affiliated with a Group, Dues: Complimentary. If not affiliated with a Group, Dues: $50.**

☐ **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.**

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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 Wisconsin Association of Hematology and Oncology.

_____ _____
Signature Date