

1. Applicant Information

Hospital/Group Practice Name _____

Cancer Program Name (if different from above) _____

Type of Program Hospital Physician Group Practice Other (please explain) _____

Medicare Provider # _____ (Each membership should represent one cancer program, which is defined as having a single Medicare provider number.) If you have questions, call ACCC Membership at 301.984.9496, (ext. 226).

Address _____

City _____ State _____ Zip _____

Website Address _____

Telephone Number: () _____ Fax Number: () _____

Name of Person Filling Out this Form _____

Title: _____ Email: _____

2. Delegate Representative* Information

Name _____ Degree _____

Title _____

Address (if different from above) _____

Email _____

Telephone Number: () _____ Fax Number: () _____

Each applicant must designate a Delegate Representative to serve as a key contact to ACCC.

*The Delegate Representative's responsibilities include:

- Keep ACCC informed of staff changes and contact information
- Vote for Board of Trustees, and Nominating Committee positions
- Distribute notices of Bylaws addenda and business meeting notices
- Serve as the contact to receive the ACCC dues invoice
- Communicate to colleagues about ACCC programs and services

3. Dues Payment

Our cancer program wishes to apply for membership. Our payment of \$1,095 is enclosed.

We understand this constitutes our first-year dues once our application has been approved.

(Check should be made payable to Association of Community Cancer Centers.)

Check Visa MasterCard American Express

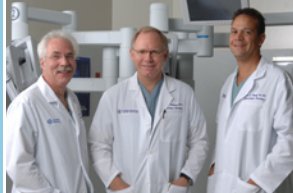
Acct. # _____ Exp. Date _____

Card Holder: _____

Card Holder Signature: _____

Note: ACCC membership is established on a fiscal year basis (July 1 through June 30). New members who join on or after December 1 shall be charged at the rate of one-half the annual dues. The remaining half will be applied towards the following year's dues.

Cancer Program Membership Application



Oncologists from Florida Hospital Cancer Institute, Orlando, Fla.



Cancer care team from John & Dorothy Morgan Cancer Center, Allentown, Pa.

4. Indicate That Your Cancer Program Meets the Following ACCC Membership Criteria:

- Diagnose and/or treat a minimum of 100 patients per year
- Have access to or participate in a Multidisciplinary Cancer Committee
- Have at least one board-certified medical oncologist, radiation oncologist, or surgeon
- Have at least one oncology-certified nurse (OCN) or one who has been specifically trained in the care of patients with cancer
- Provide oncology social work services (onsite or by referral)

5. Cancer Program Narrative Description

THIS INFORMATION IS MANDATORY FOR APPLICATION APPROVAL.

On a separate sheet of paper, please attach a short description of your cancer program. Or, you may email this text directly to membership@accc-cancer.org. Be sure to include the full name and address of your cancer program, so we can match your description to this application.

6. Photograph or Logo of Your Cancer Program Facility

A color photograph of your facility will appear on your online page on ACCC's website. You may email the photo in jpg or gif format to membership@accc-cancer.org. Logos are accepted in lieu of a photo.

(This is not mandatory for application submission but will enhance your program's online profile.)

Hold Harmless Agreement

"By submitting this application, the undersigned applicant agrees not to bring any action, suit, or proceeding or to assert any claim against ACCC or any of its members, officers, agents, or contractors, in law or in equity otherwise, relating to any decisions made in connection with this application or any action taken (or not taken) or any statement made in the course of their consideration of this application, and applicant expressly waives any rights it might otherwise have had to bring any such action, suit, proceeding, or to make any such claim."

Signature: _____ Date: _____

Next Steps

- 1 This completed application is sent to the Membership Committee to be recommended to the Board for acceptance.
- 2 A new member welcome packet is sent to the designated Delegate Representative, which includes a request for names and contact information of the members of the cancer care team. The Delegate Representative should fill out and return the requested contact information by the assigned deadline.

Mail completed form to:

Association of Community Cancer Centers
Membership Department
11600 Nebel St., Suite 201, Rockville, MD 20852
Phone: 301.984.9496 Fax: 301.770.1949
Email: membership@accc-cancer.org



Date application received (ACCC use only) _____