Cancer Program Membership Application

Association of Community Cancer Centers

1. Applicant Information

Hospital/Group Practice Name_____

Cancer Program Name_____

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. 215.

System Name (If applicable)_____

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 ( )_____

☐ I would like to serve on a committee or task force.

*Each applicant must designate a Delegate Representative to serve as a key contact to ACCC. The Delegate Representative responsibilities include: providing names of all cancer program staff to receive benefits, processing the ACCC annual dues invoice, and sharing information about your cancer program.

3. Dues Payment

☐ Our cancer program wishes to apply for membership. Our payment of $1,200 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.

(continued)

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(continued)

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.
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 the ACCC 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:_____

Mail completed form to:

Association of Community Cancer Centers
Membership Department
1801 Research Blvd. Suite 400, Rockville, MD 20850
Phone: 301.984.9496 • Fax: 301.770.1949
Email: membership@accc-cancer.org
accc-cancer.org

ACCC
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