



APPLICATION FOR MEMBERSHIP

Save this form to your computer, complete, and mail to the address shown above. If you have any questions, please contact the Membership Department, at 301.984.9496, ext. 217.

SELECT THE TYPE OF ANNUAL MEMBERSHIP:

- Regular:** Physician, MD or DO, residing or practicing in Nevada, the majority of whose practice is related to the treatment of cancer patients, such as medical oncologists, radiation oncologists, or gynecologic oncologists. **Dues: \$100.**
- Group:** Four physicians of a group practice, hospital, or university who meet the requirements of regular membership qualify for Group membership. **Dues: \$400 per practice, hospital, or university group of four physicians.** Additional physicians who meet the requirements may each join as part of the Group. **Dues \$75 each.***
- Retired:** Oncologist eligible to be a Regular member but is retired. **Dues: Complimentary.**
- Associate:** Non-physician allied health professional who is involved in the care or management of cancer patients. **Dues: \$50.**
- Fellow:** Physician enrolled in an approved oncology/hematology specialty training program in the state of Nevada. **Dues: Complimentary.**

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

FIRST NAME & MIDDLE INITIAL: _____

LAST NAME: _____

SUFFIX: _____

DEGREE: _____

TITLE: _____

INSTITUTION: _____

DEPARTMENT: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY, STATE, ZIP CODE: _____

PHONE AND FAX (+ AREA CODE): _____

EMAIL: _____

SPECIALTY: _____

PRACTICE ADMINISTRATOR: _____

PRACTICE ADMINISTRATOR'S EMAIL: _____

CHECK PRACTICE VENUE: ACADEMIC HOSPITAL OFFICE BASED

I'D LIKE TO SERVE IN A LEADERSHIP POSITION: YES NO



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 Nevada Oncology Society.

Signature

Date

NOTE: The cost of the ACCC Journal *Oncology Issues* is automatically deducted from membership dues at a rate of \$10 per subscription. The portion of dues allocated to subscription is non-deductible.

Annual membership dues (July 1–June 30) must accompany application. If paying by check, please make check payable to: Nevada Oncology Society.

PAYMENT METHOD

Check
 Visa MasterCard American Express

Acct. Number

Expiration Date CSV Code

Card Holder

Card Holder Signature

If billing address is different from mailing address please provide address below.

Address: _____

Mail payment and this application to: Nevada Oncology Society; 1801 Research Boulevard, Suite 400; Rockville, MD 20850.