

## 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](mailto: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 5 physicians \$750 (Small), 6-10 physicians \$1,000 (Medium), 11+ physicians \$1,500 (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: \$200.**
- ☐ **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.**

(CONTINUE TO NEXT PAGE)

**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 New Mexico Society of Clinical Oncology.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date