HAWAII SOCIETY OF CLINICAL ONCOLOGY

Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.hsco-hawaii.com

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 oncologist specialist in active practice in HI and US Associated Pacific Territory. **Dues: $100.00.**
- ☐ **Associate:** Allied healthcare professional who is interested or involved in the care of patients with cancer. **Dues: $25.**
- ☐ **Retired:** Individual eligible to be a Regular member but is no longer in active practice. **Dues: Complimentary.**
- ☐ **Member in Training:** Healthcare professional in an approved hematology-oncology subspecialty training program or any student with a strong interest in hematology-oncology and is sponsored by an active member. **Dues: Complimentary**
- ☐ **Group:** Four physicians in a healthcare institution (hospital or academic) or group practice who meet the requirements of Regular membership qualify for Group membership. **Dues: $400 per group of four physicians.** Additional physicians who meet the requirements may each join as part of the Group. **Dues: $75 each.*** Each group may enroll up to five support (non-physician) staff as Associate members. Additional support staff may join at $25 each. Any group that is also a Cancer Program Member of ACCC may add an unlimited number of associate members at no extra charge.

**** Group: On a separate sheet of paper, please list additional Regular and Associate members included in the Group membership and their corresponding contact information and submit it to the HSCO 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): ____

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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 Hawaii Society of Clinical Oncology.

____ ______________________________

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 (January 1–December 31) must accompany application. If paying by check, please make check payable to: Hawaii Society of Clinical Oncology.

PAYMENT METHOD
_ Check
_ Visa _ MasterCard _ American Express

____
Acct. Number
____
Expiration Date CSV Code
____
Card Holder
____

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Card Holder Signature

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

Address: ____

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Mail payment and this application to: Hawaii Society of Clinical Oncology; 1801 Research Boulevard, Suite 400; Rockville, MD 20850