APPLICATION FOR MEMBERSHIP

Annual membership dues (July 1–June 30) must accompany application. Mail payment with this form to: Indiana Oncology Society; 1801 Research Boulevard, Suite 400; Rockville, MD 20850.

If you have any questions, please contact the Membership Department at ossmembership@accc-cancer.org.

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 10 physicians $1,000 (Small), 11-25 physicians $1,500 (Medium), 26+ physicians $2,000 (Large). All affiliated allied health professionals are complimentary.

  Select your organization from the list of existing Groups. If your organization is listed, your Group administrator will cover the dues indicated above. If your organization is not listed, select the option to start a new Group or select another type of membership. Fellows should always select the "Fellow" type of membership even if their organization is listed below.

  - American Health Network Hematology/Oncology Associates
  - Cancer Health Treatment Centers, PC
  - Fort Wayne Medical Oncology & Hematology, Inc.
  - Hematology-Oncology of Indiana, PC
  - Indiana University Medical Center
  - IU Health Central Indiana Cancer Centers
  - Michiana Hematology-Oncology, PC
  - Oncology/Hematology Associates of SW Indiana
  - I would like to start a new Group! Contact me at the information provided on the next page.


- **Allied Health Professional**: Healthcare staff including but not limited to registered nurses, nurse practitioners, clinical nurse specialists, pharmacists, physician assistants, administrators, social workers, and office managers. **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 physicians and allied health professionals who are no longer practicing. **Dues**: Complimentary

(TURN OVER)
COMPLETE YOUR INFORMATION:

FIRST NAME: ___________________________  LAST NAME: ___________________________
SUFFIX: ______________________________  CREDENTIALS: _____________________________
TITLE: ___________________________________________________________________________
INSTITUTION: _____________________________________________________________________
DEPARTMENT: _____________________________________________________________________
ADDRESS 1: _____________________________________________________________________
ADDRESS 2: _____________________________________________________________________
CITY, STATE, ZIP CODE: ___________________________________________________________
PHONE AND FAX (+ AREA CODE): ___________________________________________________
EMAIL: __________________________________________________________________________

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 Indiana Oncology Society.

_________________________________________  _____________________________
Signature                                      Date