APPLICATION FOR MEMBERSHIP

Complete and mail this form to the address shown at the bottom. If you have any questions, please contact the Membership Department, at 301.984.9496, ext. 230 or ckim@accc-cancer.org.

Annual membership dues (July 1–June 30) must accompany application. Please make check payable to: Minnesota Society of Clinical Oncology.

SELECT THE TYPE OF ANNUAL MEMBERSHIP:

☐ Regular: Physician oncology and hematology specialist in MN. Dues: $200.

☐ Group: Five or more physicians in a healthcare institution (practice or university) or group practice who meet the requirements of Regular membership qualify for Group membership. Dues: $1,000 per practice or university with 5–7 members. Dues: $1,500 per practice or university with 8 or more members.


☐ Affiliate: Allied healthcare professional interested in the care and treatment of persons with cancer, cancer registrars, administrators, managers, business staff, social workers, and others. Dues: Complimentary.

☐ Fellow: Healthcare professional participating in an oncology or hematology subspecialty training program. Dues: Complimentary.

☐ Retired: Physician eligible to be a Regular member but is no longer practicing. Dues: Complimentary.

* Group: On a separate sheet of paper, please list additional Regular members included in the Group membership and their corresponding contact information and submit to the MSCO Executive Office.

FIRST NAME & MIDDLE INITIAL: _______________________________________________________
LAST NAME: _______________________________________________________________________
SUFFIX: __________________________________________________________________________
DEGREE: __________________________________________________________________________
TITLE: ____________________________________________________________________________
INSTITUTION: _____________________________________________________________________
DEPARTMENT: _____________________________________________________________________

Oncology State Societies at ACCC
Engage & Succeed.
ADDRESS 1: _______________________________________________________________________
ADDRESS 2: _______________________________________________________________________
CITY, STATE, ZIP CODE: ____________________________________________________________
PHONE AND FAX (+ AREA CODE): ______________________________________________________
EMAIL: __________________________________________________________________________
SPECIALTY: _______________________________________________________________________

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 Minnesota 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.

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