APPLICATION FOR MEMBERSHIP

Annual membership dues (July 1–June 30) must accompany application. Mail payment and this form to: Minnesota Society of Clinical Oncology; 1801 Research Boulevard, Suite 400; Rockville, MD 20850. If you have any questions, please contact the Membership Department, at 301.984.9496, ext. 230 or ckim@accc-cancer.org.

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: ________________________________ LAST NAME: ________________________________

SUFFIX: ________________________________ DEGREE: ________________________________

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 Minnesota Society of Clinical Oncology.

______________________________  ______________________________
Signature                                      Date

Oncology State Societies at ACCC
Engage & Succeed.