ROCKY MOUNTAIN ONCOLOGY SOCIETY

Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.rmos-colorado.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:** Licensed physician with interest in oncology. **Dues: $100.**
☐ **Associate:** Allied healthcare professional in Colorado who is interested or involved in the care of cancer patients. **Dues: Complimentary.**
☐ **Honorary:** Retired physician, no longer practicing medicine. **Dues: Complimentary.**
☐ **Professional in Training:** Resident or intern interested in oncology. **Dues: Complimentary.**

FIRST NAME & MIDDLE INITIAL: _____

LAST NAME: _____

SUFFIX: _____

DEGREE: _____

TITLE: _____

INSTITUTION: _____

DEPARTMENT: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY, STATE, ZIP CODE: _____

PHONE AND FAX (+ AREA CODE): _____

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 Rocky Mountain Oncology Society.

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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: Rocky Mountain Oncology Society.

PAYMENT METHOD

_ Check
_ Visa _ MasterCard _ American Express

_____
Acct. Number

_____
Expiration Date CSV Code

_____
Card Holder

_____
Card Holder Signature

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

Address: _____

_____

_____

Mail payment and this application to: Rocky Mountain Oncology Society; 1801 Research Boulevard, Suite 400; Rockville, MD 20850