ILLINOIS MEDICAL ONCOLOGY SOCIETY

Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.imos-illinois.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 oncology and/or hematology specialist who is licensed, certified or eligible to be certified, and practices in Illinois. **Dues: $200.**
- ☐ **Group:** Four physicians in an oncology practice or university who meet the requirements of Regular membership qualify for Group membership. **Dues: $800 per practice or university**. Additional physicians who meet the requirements may each join as part of the Group and have the same privileges as Regular members. **Dues: $50 each.***
- ☐ **Associate:** Allied healthcare professionals including but not limited to registered nurses, nurse practitioners, physician assistants, pharmacists, cancer registrars, administrators, office managers, or other health professionals. **Dues: $50 each.**
- ☐ **Fellow:** Healthcare professional participating in an oncology subspecialty training program in IL. **Dues:** Complimentary.
- ☐ **Retired:** Individual eligible to be a Regular member but is no longer practicing oncology. **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 it to the IMOS 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): _____

EMAIL: _____

SPECIALTY: _____

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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 Illinois Medical Oncology Society

_____ _____
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 (July 1–June 30) must accompany application. If paying by check, please make check payable to: Illinois Medical 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: Illinois Medical Oncology Society; 1801 Research Boulevard, Suite 400; Rockville, MD 20850