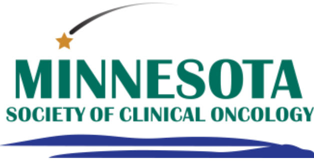


MINNESOTA SOCIETY OF CLINICAL ONCOLOGY

Executive Office:
1801 Research Boulevard, Suite 400, Rockville, Maryland 20850
Phone: 301.984.9496 Fax: 301.770.1949
www.msco-minnesota.com

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. 217.

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.

☐ **Associate:** Allied healthcare professional involved in care and treatment of persons with cancer including registered nurses, nurse practitioners, and physician assistants. **Dues: $25.**

☐ **Affiliate:** Allied healthcare professional interested in the care and treatment of persons with cancer including pharmacists, 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: ____

ADDRESS 1: ____

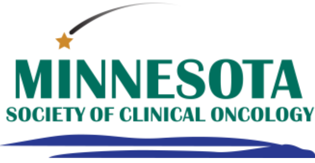
ADDRESS 2: ____

CITY, STATE, ZIP CODE: ____

PHONE AND FAX (+ AREA CODE): ____

EMAIL: ____

SPECIALTY: ____



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PRACTICE ADMINISTRATOR'S NAME: ____

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 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.

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

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

PAYMENT METHOD

_ Check
_ Visa _ MasterCard _ American Express
____
Acct. Number
____
Expiration Date CSV Code
____

Card Holder
____
Card Holder Signature

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

Address: ____

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