

ASPHO Group Membership Application for Fellows/Trainees

ASPHO encourages membership among trainees throughout the course of their fellowship, providing career development, advanced knowledge, and professional network resources for pediatric hematology/oncology subspecialists. By completing this form, program directors can sign up their institution's trainees for ASPHO membership to support their professional development. Trainee memberships are available for \$50, or \$100 with the Clinical Video Series Hematology/Oncology Bundle as part of the membership package.

Trainee members must be enrolled and in good standing in an accredited fellowship program with enrollment verified by a supervisor. Trainee members may serve on Society committees and participate in special interest groups. Trainees receive full member benefits including a personal subscription to ASPHO's official journal, *Pediatric Blood & Cancer.*

Name		Credentials		
Preferred Mailing Address (□ home □ work)			Membership Options	
City			□ \$50 Trainee Membership	
Alternate Mailing Address (☐ home ☐ work)			☐ \$100 Trainee Membership	
City	State	ZIP	•	
Phone (home cell)	E-mail (🗖 home	□ work)	vork) Subtotal \$	
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion		_	
Name		Credentials	Membership Options	
Preferred Mailing Address (☐ home ☐ work)			□ \$50 Trainee Membership	
City	State	ZIP		
Alternate Mailing Address (□ home □ work)			—— plus	
City	State	ZIP	Clinical Video Series H/O Bundle	
Phone (home cell)	E-mail (home work)		Subtotal \$	
National Provider Identifier (NPI)	Anticipated Year o	of Fellowship Completion		
Name		Credentials	Membership Options	
Preferred Mailing Address (home work)			□ \$50 Trainee Membership	
City	State	ZIP		
Alternate Mailing Address (☐ home ☐ work)				
City	State	ZIP	Clinical Video Series H/O Bundle	
Phone (home cell)	E-mail (home work)		Subtotal \$	
National Provider Identifier (NPI)	Anticipated Year o	of Fellowship Completion		
			Total \$	
I verify that all the individuals listed above	are currently employed at		(name of institution	
Program Director Name/Credentials		[Date	
Signature		Department		
Institution				
Address				
City		State	ZIP	
Form of Payment (Payment must be	e in U.S. funds only.)			
☐ MasterCard ☐ Visa ☐ American Expr	ess 🖵 Discover 🖵 Chec	ck (Payable to the American Society of P	ediatric Hematology/Oncology)	
	Expiration Date			

Please return the completed form to ASPHO Member Services by fax (847.375.6483) or mail to:

American Society of Pediatric Hematology/Oncology, PO Box 3781, Oak Brook, IL 60522

Questions? The Member Services team can be reached by phone 8 am-6 pm CST at 847.375.4716 or email to info@aspho.org