

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 ASPHO Conference Recording 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*.

## To be completed by program director

Name	Credentials	Membership Options
Preferred Mailing Address ( $\Box$ home $\Box$ work)		
City	StateZIP	□ \$100 Trainee Membership
Alternate Mailing Address (		plus
City	StateZIP	ASPHO Conference Recording
Phone ( home cell)	E-mail (🗆 home 🛛 work)	Subtotal \$
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
Name	Credentials	Membership Options
Preferred Mailing Address ( home work)		
City	StateZIP	□ \$100 Trainee Membership
Alternate Mailing Address ( home work)		
City	StateZIP	ASPHO Conference Recording
Phone ( home Cell)	E-mail (  home	Subtotal \$
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
Name	Credentials	Membership Options
Preferred Mailing Address ( home work)		□ \$50 Trainee Membership
City	StateZIP	□ \$100 Trainee Membership
Alternate Mailing Address (		— plus
City	StateZIP	ASPHO Conference Recording
Phone ( home cell)	E-mail ( home vork)	Subtotal \$
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
		Total \$
I verify that all the individuals listed above are c	currently employed at	(name of institution).
Program Director Name/Credentials		_ Date
Signature	Department	
Institution		
Address		
City	State	ZIP
Form of Payment (Payment must be in L	S funds only)	
	Discover     Check     (Payable to the American Society	of Pediatric Hematology/Oncology)
Account Number	Expiration Da	te
Signature		
Please return the completed form to ASPHC American Society of Pediatric Hematology/O	D Member Services by fax (847.375.6483) or mail t ncology, PO Box 3781, Oak Brook, IL 60522	10:

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