



aspHO Membership Application

The American Society of
Pediatric Hematology/Oncology

Join ASPHO—the only organization dedicated to the professional development and interests of PHO subspecialists.

Please complete this form and provide all information requested.

New members must be endorsed by a current ASPHO member (see below). Trainees must provide program director or supervisor name and e-mail address for ASPHO confirmation. A [Group Trainee Membership Application](#) is available for enrolling multiple fellows from an institution.

Membership Type (Please check the membership status that applies to you.)

- Regular Member \$380
- Regular Member, 2-year membership..... \$760
- Regular Member, 1-year post-training..... \$125
- Allied Member \$165
- Trainee Member (first, second, and third years)* \$50 membership only \$100 membership with Conference Recording
- Trainee Member (fourth year)..... \$125
- Trainee Member (fifth year)..... \$125
- International Member (*high- and upper-middle-income economies*[†])..... \$380
- International Member (*lower middle-/low-income economies*[†]) \$85

*First- through third-year trainee memberships are available for \$50, or \$100 with the ASPHO Conference Recording as part of the membership package.

[†]Refer to World Bank data.

General Information

The following information is required. Only professional affiliation and contact information will be published in the online membership directory.

Please check here if you do NOT want to be listed in the online directory.

Name _____
(first) (middle initial) (last)

Credentials _____

Title/Department _____

Facility/Hospital or University _____

Facility Address _____

Home City/State/ZIP or Postal Code _____ Country _____

Daytime Phone _____ E-Mail _____

Trainees: Please add home and work e-mail addresses.

If you prefer to receive ASPHO mailings at home, please provide your home address:

Home Address _____

Home City/State/ZIP or Postal Code _____ Country _____

New members must be endorsed and signed for by a current member of ASPHO in good standing. Trainee applications must include program director or supervisor name and e-mail address for ASPHO confirmation.

I recommend this individual for membership in ASPHO.

Member Name _____

I am program director/supervisor for trainee member applicant

Institution _____ E-Mail _____

Form of Payment (Payment must be in U.S. funds only.)

MasterCard Visa American Express Discover Check (*Payable to the American Society of Pediatric Hematology/Oncology*)

Account Number _____ Expiration Date _____

Signature _____

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 by email to info@aspho.org.