ASPHO Group Membership Application for Fellows/Trainees

aspho
The American Society of Pediatric Hematology/Oncology

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.*

To be completed by program director

Name______________________ Credentials______________

Preferred Mailing Address (❒ home ❒ work) ______________________

City ______________________ State__________ ZIP ______________

Alternate Mailing Address (❒ home ❒ work) ______________________

City ______________________ State__________ ZIP ______________

Phone (❒ home ❒ cell) ______________E-mail (❒ home ❒ work) ______________

National Provider Identifier (NPI) ______________ Anticipated Year of Fellowship Completion ______________

Membership Options

❒ $50 Trainee Membership

❒ $100 Trainee Membership
plus
100 Self-Assessment Questions

Subtotal $ ______________

Name______________________ Credentials______________

Preferred Mailing Address (❒ home ❒ work) ______________________

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Subtotal $ ______________

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 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 email to info@aspho.org