

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 100 self-assessment questions 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 program director. 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 \_\_\_\_\_  
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 Alternate Mailing Address ( home  work) \_\_\_\_\_  
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 \$100 Trainee Membership  
**plus**  
 100 Self-Assessment Questions

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 CT at 847.375.4716 or email to [info@aspho.org](mailto:info@aspho.org)