aspho Membership Application

The American Society of Pediatric Hematology/Oncology

ASPHO—Dedicated to supporting and empowering the pediatric hematology and oncology medical and scientific community.

Please complete this form and provide all information requested.

Member categories are described on aspho.org. Trainee, resident, and medical student applicants must provide verification information below 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 $395
❑ Regular Member, 2-year membership $790
❑ Regular Member, 1-year post-training $130
❑ Allied Member $175
❑ Trainee Member (first, second, and third years)* ..... ☑ *$50 membership only* ❑ *$100 membership with 100 self-assessment questions*
❑ Trainee Member (fourth year) $130
❑ Trainee Member (fifth year) $130
❑ Resident $50
❑ Medical Student $35
❑ International Member *(high- and upper-middle–income economies†)* $395
❑ International Member *(lower middle-/low-income economies†)* $95

**First- through third-year trainee memberships are available for $50, or $100 with 100 self-assessment questions 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 _____ Credentials _____
(first) (middle initial) (last)

Title/Department _____

Institution/Hospital or University _____

Institution Address _____

City/State/ZIP or Postal Code _____ Country _____

Daytime Phone _____ E-Mail _____

Trainees, Residents, and Medical Students: Please add home and work e-mail addresses.
If you prefer to receive ASPHO mailings at home, please provide your home address:

Home Address _____

City/State/ZIP or Postal Code _____ Country _____

Trainee, resident, and medical student applications require program director/dean verification, with additional information required for resident and medical student applicants (see aspho.org/membership).

❑ I am program director for trainee member or resident applicant: _____
(Program Director Name) (Credentials)

❑ I am program dean for medical student member applicant: _____
(Program Dean Name) (Credentials)

Year of Program Completion: __ __ __ __

Institution _____ Program Director/Dean 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–5:30 pm CT at 847.375.4716 or by email to info@aspho.org.