# 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 ..... $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
❑ 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 _____
(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 8:30 am–5 pm CT at 847.375.4716 or by email to info@aspho.org.