

**Please complete this form and provide all information requested.**

Member categories are described on [aspho.org](http://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 ..... \$405
- Regular Member, 2-year membership..... \$810
- Regular Member, 1-year post-training ..... \$135
- Allied Member ..... \$180
- Trainee Member (first, second, and third years)\* .....  \$50 membership only  \$100 membership with 100 self-assessment questions
- Trainee Member (fourth year) ..... \$135
- Trainee Member (fifth year) ..... \$135
- Resident ..... \$50
- Medical Student ..... \$35
- International Member (high- and upper-middle-income economies†)..... \$405
- 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](http://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 at [www.aspho.org](http://www.aspho.org).