aspho The American Society of Pediatric Hematology/Oncology

Membership Application

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 $380
❏ Regular Member, 2-year membership $760
❏ Regular Member, 1-year post-training $125
❏ Allied Member $165
❏ Trainee Member (first year)* .... *Complimentary*
❏ Trainee Member (second year)* .... *Complimentary*
❏ Trainee Member (third year)* .... *Complimentary*
❏ Trainee Member (fourth year) $125
❏ Trainee Member (fifth year) $125
❏ International Member *(high- and upper-middle–income economies**)* $380
❏ International Member *(lower middle-/low-income economies**)* $85

**Complimentary trainee membership excludes journal subscription.*

***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 e-mail (info@aspho.org) or 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.

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