

ASPHO Group Membership Application for Fellows/Trainees

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	Membership Options
Preferred Mailing Address (\square home \square work) $_$		
City	State ZIP	□ \$100 Trainee Membership
		plus
City	StateZIP	100 Self-Assessment Questions
Phone (home cell)	E-mail (home work)	Subtotal \$
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
Name	Credentials	Membership Options
Preferred Mailing Address (\square home \square work) $_$		□ \$50 Trainee Membership
City	State ZIP	
,		plus
City	State ZIP	100 Self-Assessment Questions
	E-mail (home work)	
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
Name	Credentials	Membership Options
Preferred Mailing Address (\square home \square work) $_$		
City	State ZIP	□ \$100 Trainee Membership
Alternate Mailing Address (☐ home ☐ work)		
City	StateZIP	100 Self-Assessment Questions
Phone (home cell)	E-mail (home work)	Subtotal \$
National Provider Identifier (NPI)	Anticipated Year of Fellowship Completion	
		Total \$
I verify that all the individuals listed above ar	re 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	n U.S. funds only.)	
☐ MasterCard ☐ Visa ☐ American Express	s □ Discover □ Check (Payable to the American Society of F	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 88019, Chicago, IL, 60680-8019

Questions? The Member Services team can be reached by phone 8 am-6 pm CT at 847.375.4716.