

PROFESSIONAL INFORMATION

Florida License Number (if applicable): _____

Training or interested in the following Specialties:

- Dermatology
- Pediatrics (only)
- Gynecologic Oncology
- Pharmacology (clinical)
- Hematology (only)
- Internal Medicine (only)
- Psychiatry/Psychology
- Medical Oncology (only)
- Radiation Oncology
- Medical Oncology/Hematology
- Surgery (Surgical Oncology & Surgical Specialties)
- Nuclear Medicine
- Pathology
- Pediatric Hematology
- Pediatric Oncology (only)
- Pediatric Oncology/Hematology
- Other (please specify) _____

EDUCATION

(CV may be attached in lieu of completing this section.)

1. University Attended/Attending: _____

City: _____ State: _____

Dates: _____ Degree: _____

2. University Attended/Attending: _____

City: _____ State: _____

Dates: _____ Degree: _____

TRAINING / CERTIFICATION

(If this information is in your CV, please mark this section "Please See Attached CV.")

If applicable, please list your post-graduate training (internship, residency, fellowship, etc.). Include start/end date, institution, location and title.

REQUIRED ATTACHMENTS

- Reference letter from the Training Program Director.

APPLICANT SIGNATURE

Applicant Signature: _____

Date: _____

Please mail completed application form and required attachments to:

**Dorothy Green Phillips
Executive Director
Florida Society of Clinical Oncology
10022 Water Works Lane
Riverview, FL 33578**