



## REGULAR MEMBERSHIP APPLICATION

### **DEMOGRAPHIC INFORMATION**

**Note: Please type all required information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Degree: MD \_\_\_\_\_ DO \_\_\_\_\_ PhD \_\_\_\_\_ PharmD \_\_\_\_\_ Other \_\_\_\_\_

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Resident of Florida since: \_\_\_\_\_

***Business/Institution/Organization Address:***

Firm Name: \_\_\_\_\_

Institution/Organization Name: \_\_\_\_\_

Department/Division: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-mail address: \_\_\_\_\_

***Home Address:***

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax #: \_\_\_\_\_

E-mail address: \_\_\_\_\_

***Preferred Mailing Address:*** \_ Firm, organization/institution \_\_\_\_\_ Home: \_\_\_\_\_

## PROFESSIONAL INFORMATION

**Florida License Number:** \_\_\_\_\_

*Required: Board Certification(s) or International equivalent(s) – Please attach a copy of these documents*

### **Board Certified Specialties:**

- Dermatology
- Gynecologic Oncology
- Hematology (only)
- Internal Medicine (only)
- Medical Oncology (only)
- Medical Oncology/Hematology
- Nuclear Medicine
- Oncology Nursing Non Board Certified Work, etc.)
- Pathology
- Pediatric Hematology
- Pediatric Oncology (Only)
- Pediatric Oncology/Hematology
- Pediatrics (only)
- Pharmacology (clinical)
- Physician's Assistant
- Psychiatry
- Radiation Oncology/Psychology
- Surgery (including Surgical Oncology and Surgical Specialties)

### **Non Board Certified Activities:**

- Allied Health (e.g. Psychology, Physical Therapy, Social Work, etc.)
- Biostatistics/Epidemiology
- Health Care Administration
- Laboratory Research
- Other (please specify)

**Are you a member of the Florida Medical Association?**    \_\_\_\_\_ **yes**    \_\_\_\_\_ **no**

**Are you a member of ASCO?**    \_\_\_\_\_ **yes**    \_\_\_\_\_ **no**

***Date began oncology practice in Florida:*** \_\_\_\_\_

## EDUCATION

*(CV may be attached in lieu of completing the information in this box.)*

1.    **University Attended:** \_\_\_\_\_  
      **City & State:** \_\_\_\_\_  
      **Dates:** \_\_\_\_\_                      **Degree:** \_\_\_\_\_
  
2.    **University Attended:** \_\_\_\_\_  
      **City & State:** \_\_\_\_\_  
      **Dates:** \_\_\_\_\_                      **Degree:** \_\_\_\_\_
  
3.    **University Attended:** \_\_\_\_\_  
      **City & State:** \_\_\_\_\_  
      **Dates:** \_\_\_\_\_                      **Degree:** \_\_\_\_\_

***TRAINING/CERTIFICATION:*** (If this information is included in your attached CV you may mark this section: "Please see attached CV.")

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

**WHERE HAVE YOU PREVIOUSLY PRACTICED MEDICINE: (Please provide location, dates and type of practice)**

**POST GRADUATE WORK SINCE GRADUATION (specific oncology training)**

**HOSPITAL STAFF APPOINTMENTS AND POSITIONS IN FLORIDA:**

## SPECIALTY INFORMATION

Is your practice limited to a specialty? Yes \_\_\_\_\_ No \_\_\_\_\_ Specify: \_\_\_\_\_

Diplomat of National Board of Specialty? Yes \_\_\_\_\_ No \_\_\_\_\_ Specialty:  
\_\_\_\_\_

Eligibly for National Board of Specialty? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list memberships in National Societies or specialty groups, including sectional organizations:

## OTHER INFORMATION

*Have you ever been suspended from, or denied privileges on any hospital staff? Yes \_\_\_\_\_ No \_\_\_\_\_*

*Member of the following Medical Societies:*

*Member of the following other medical and civic organizations:*

## REQUIRED ATTACHMENTS

1. Current CV
2. Copy of Board Certificates or Equivalentents
3. Check payable to Florida Society of Clinical Oncology, for dues in the amount of **\$250.00**

## 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**

**Tel: 813.677.0246 Ext. 102...Fax: 813.677.0559..Email: [dorothy.green@flasco.org](mailto:dorothy.green@flasco.org)**