



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 Equivalent
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
3709 W. Jetton Ave.
Tampa, Florida 33629**