

Oklahoma Society of Clinical Oncology

Application for Affiliate Membership

Please print or type.

Full Name _____ Degree(s) _____

Date of Birth _____ Home County _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Home Fax (____) _____

Employed by _____

Office Address _____

City _____ State _____ Zip _____

Office Phone (____) _____ Fax (____) _____

E-mail _____

Undergraduate School _____

Degree Received _____ Year of Graduation _____

Graduate School/Certification Program _____

Degree/Certificate received _____ Year of Graduation _____

OK State License Number _____ Expires _____

Other License Number _____ Expires _____

Other current professional organization memberships.

List practice, clinic, hospital, or surgical/treatment center with which you are affiliated.

1. _____

2. _____

3. _____

Please briefly describe the nature of your oncologic activities, including a description of your practice, specific interests, and percent of time devoted to cancer patients.

_____ Date _____

Signature of Applicant

Annual dues: \$20.00

Any questions? Call: (918) 274-8374 or (866) 691-OSCO
 Fax: (918) 274-8354
 E-mail: osco@oscoOK.org

Please return completed application and dues to:

Mary Jo Wichers
Oklahoma Society of Clinical Oncology
8805 N. 145th E. Ave, Ste 203
Owasso, OK 74055