## Application for Affiliate Membership

*Please print or type.*

**Name: _______________________________________________Degree(s): ___________________**
**Date of Birth: __________________________________________**
**City: ______________________________State:_________Zip:_______________**
**Home Phone: (_____) ______________________Home Fax: (_____) __________________________**

**Employed by: ______________________________________________________________________**
**Office Address #1: __________________________________________________________________**
**City: ___________________________Sate:____________ Zip: ___________County: ____________**
**Office Phone: (_____) _________________Fax: (_____) ________________E-Mail: ______________**

**Office Address #2: _________________________________________________________________**
**City: ___________________________Sate:____________ Zip: ___________County: ____________**
**Office Phone: (_____) _________________Fax: (_____) ________________E-Mail: _______________**

**Undergraduate School: _________________________________From: __________ To: ___________**
**Degree Received: ______________________________Year of Graduation: _______________**
**Graduate School: ____________________________________From: ___________ To: ___________**
**Degree/Certificate received: _________________________ Year of Graduation: __________**

**OK State License Number: _____________________________ Expires: _______________________**
**Other License Number: _______________________________ Expires: _________________________**

**Other current professional organization memberships**
_________________________________________________________________________________
_________________________________________________________________________________

**Current Hospital where you have Privileges:**

1. ___________________________________
2. ___________________________________
3. ___________________________________

**In the space provided, please briefly describe the nature of your oncology activities, including a description of your medical practice, specific interests, and percent of time devoted to cancer patients.**

**Signature: ___________________________________________Date:__________________**

**Annual Dues: $20.00/each**

**Questions:**

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**Fax: 918-274-8354**
**Email: MaryJo@oscook.org**
**Mail: OSCO**
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**Owasso, OK 74055**