



## Application for Affiliate Membership

*Please print or type.*

Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ Home Fax: (\_\_\_\_) \_\_\_\_\_

Employed by: \_\_\_\_\_

Office Address #1: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Office Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Office Address #2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ 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

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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:

Call: 918-274-8374

Fax: 918-274-8354

Email: [MaryJo@oscook.org](mailto:MaryJo@oscook.org)

Mail: OSCO

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