

Application for Affiliate Membership

Affiliate Members are individuals qualified for Active Membership yet may incur hardship complying with the attendance requirement. Affiliate members attendance requirement will be expanded to include participation in webcasts, teleconferences, and/or meetings (2 X a year).

Annual Dues: \$500.00

Please mail the signed application and payment to POHMS' Member Services
P.O. Box 30, Hummelstown, PA 17036 ~ Phone: 717-514-8371 ~ Fax: 717-566-3003 ~ Visit www.pohms.com

Applicant Information (Please type or print clearly.)

Name _____

First

Last

Title/Position: _____

Please indicate:

MD

PhD

PharmD

BA

RN

MSN

MS

Other _____

Email Address: _____

Date of Birth: ____ / ____ / ____

mm

dd

yy

Gender:

Male

Female

Practice

Name _____

Address _____

City

State

Zip/Postal Code

Phone (____) _____

Fax (____) _____

Total Practice Employees: _____

Total # of RN's: _____

How Long Practice in Existence? _____

Total # of Physician Extenders: _____

Membership Application continued....

Physicians:

Please list _____

Pyxis	Y	N	EMR	Y	N
			(Specify)	_____	
Internet	Y	N			
Dial-up		DSL	High Speed/Cable		
Practice Website?	Y	N	(Specify)	_____	
Research	Y	N			
Ancillary Services:					
PET/CT		Retail Pharmacy		Complimentary Therapies	
Other(Specify)	_____				
Practice Type:					
Community-based		Hospital-owned		Hospital-based	Multi-specialty
Other (Specify)	_____				

As a member of the Pennsylvania Oncology Hematology Managers' Society I agree that my practice will be represented at not less than two webcasts, teleconferences, and/or meetings (2 X a year). I further understand that failure to comply with these membership requirements may result in the revocation of my practice membership. I also understand under these conditions, membership dues are non-refundable.

Member Name (please print): _____

Member Signature: _____ Date: _____