



Application for Membership

Annual membership dues (January 1-December 31) must accompany application.

Step 1: SELECT TYPE OF ANNUAL MEMBERSHIP:

- ☐ **Clinical Member:** All licensed physicians who are certified or eligible to be certified in oncology/hematology, radiation oncology, or other specialty that takes care of cancer patients **Dues: \$200**
- ☐ **Allied Health Member:** Allied healthcare professionals including but not limited to: physician assistants, nurse practitioners, registered nurses, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists, pharmacists, pathologists, radiation therapists, and medical dosimetrists.
Dues: \$50
- ☐ **Support Staff Member:** Medical assistants, pharmacy technicians, certified nursing assistants, office managers, social workers. **Dues: \$25**
- ☐ **Retired Members:** For retired healthcare professionals who wish to stay connected with the oncology community. **Dues: Complimentary**

Step 2: SELECT PAYMENT METHOD:

- ☐ **Check or Cash:** Mail Check to Frontier Oncology Society. P.O. Box 351, Whitefish, MT 59937 *(no fee)*
- ☐ **Credit Card:** Pay online using QR code *(a 2.9% credit card processing fee and \$0.30 transaction fee applies)*



Clinical



Allied



Support

Step 3: SUBMIT

Mail completed form (and check if applicable) to the address above, or submit payment online and email completed form to resource.fos@gmail.com

To find out about scholarship/grant opportunities or for any questions, please contact Lynette FOS Admin at resource.fos@gmail.com

Personal Information

- Full Name: _____
- Degree: _____
- Title: _____
- Organization: _____

Contact Information

- Address: _____
- City, State, ZIP Code: _____
- Phone Number: _____
- Email Address: _____

I attest that I meet the qualifications of the membership category for which I am applying, and that I will uphold the purpose(s) of Frontier Oncology Society.

Signature

Date