

# International Society for Preventive Oncology Membership Application Form

Membership Type (circle one):      Active      Associate      Junior

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Date: \_\_\_\_\_ Citizenship: \_\_\_\_\_

University: \_\_\_\_\_

Training: \_\_\_\_\_

Specialty: \_\_\_\_\_

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

Date(s): \_\_\_\_\_

Present Position & Title: \_\_\_\_\_

Affiliation (Institution): \_\_\_\_\_

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

City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Sponsorship: Please list the names and addresses of two professional colleagues.

1. \_\_\_\_\_

2. \_\_\_\_\_

**Remember to attach to this form:      (1) Curriculum Vitae      (2) Pertinent Publications**

Please remember to sign and date the form.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please remember to enclose an initiation fee of \$135.00.

Please make check in US funds payable to ISPO. International checks should name a New York bank.

### Credit Card Payments:

Please provide the information requested below. Return a signed copy of this statement with your payment.

Circle one:    VISA    MasterCard    Number: \_\_\_\_\_    Expiration Date: \_\_\_\_\_

Amount of Payment: \$ \_\_\_\_\_    Date and Signature: \_\_\_\_\_

