ASPHO Group Membership Application for Fellows/Trainees

ASPHO encourages membership among trainees throughout the course of their fellowship, providing career development, advanced knowledge, and professional network resources for pediatric hematology/oncology subspecialists. By completing this form, program directors can sign up their institution's trainees for ASPHO membership to support their professional development. Trainee memberships are available for $50, or $100 with 100 self-assessment questions as part of the membership package.

Trainee members must be enrolled and in good standing in an accredited fellowship program with enrollment verified by a program director. Trainee members may serve on Society committees and participate in special interest groups. Trainees receive full member benefits including a personal subscription to ASPHO's official journal, *Pediatric Blood & Cancer.*

To be completed by program director

Name ______________________ Credentials ______________________

Preferred Mailing Address (❐ home ❐ work) ______________________

City ______________________ State __________ ZIP __________

Alternate Mailing Address (❐ home ❐ work) ______________________

City ______________________ State __________ ZIP __________

Phone (❐ home ❐ cell) ______________________ E-mail (❐ home ❐ work) ______________________

National Provider Identifier (NPI) __________ Anticipated Year of Fellowship Completion __________

Membership Options

❐ $50 Trainee Membership

❐ $100 Trainee Membership **plus** 100 Self-Assessment Questions

Subtotal $ __________

Name ______________________ Credentials ______________________

Preferred Mailing Address (❐ home ❐ work) ______________________

City ______________________ State __________ ZIP __________

Alternate Mailing Address (❐ home ❐ work) ______________________

City ______________________ State __________ ZIP __________

Phone (❐ home ❐ cell) ______________________ E-mail (❐ home ❐ work) ______________________

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Phone (❐ home ❐ cell) ______________________ E-mail (❐ home ❐ work) ______________________

National Provider Identifier (NPI) __________ Anticipated Year of Fellowship Completion __________

Membership Options

❐ $50 Trainee Membership

❐ $100 Trainee Membership **plus** 100 Self-Assessment Questions

Subtotal $ __________

Total $ __________

I verify that all the individuals listed above are currently employed at ______________________ (name of institution).

Program Director Name/Credentials ______________________ Date __________

Signature ______________________ Department ______________________

Institution ______________________

Address ______________________

City ______________________ State __________ ZIP __________

Form of Payment (Payment must be in U.S. funds only.)

❏ MasterCard ❏ Visa ❏ American Express ❏ Discover ❏ Check *(Payable to the American Society of Pediatric Hematology/Oncology)*

Account Number ______________________ Expiration Date __________

Signature ______________________

Please return the completed form to ASPHO Member Services by fax (847.375.6483) or mail to:
American Society of Pediatric Hematology/Oncology, PO Box 88019, Chicago, IL, 60680-8019

Questions? The Member Services team can be reached by phone 8:30 am–5 pm CT at 847.375.4716.