2020 Membership Application

NAME ____ JOB TITLE ____________________________

Business Name ____

ADDRESS ____

CITY ____ STATE _________ ZIP________________

PHONE NUMBER _______________ ext ______ FAX NUMBER ________________

E-MAIL ADDRESS ____

Please provide an e-mail address -This will be our primary form of communication with you

NUMBER OF PHYSICIANS ______ NUMBER OF OFFICES ______ NUMBER OF EMPLOYEES ______

Please select all that apply:

☐ MedOnc ☐ RadOnc ☐ GynOnc ☐ Surgical Oncology ☐ Other Specialty ☐Affiliate

NUMBER OF STAFF SUPERVISED ______

*Full Membership requires that you supervise at least 2 additional coworkers

☐Transfer membership from ____ to_______________________________

Membership Type:

☐ Full Practice Member $100 ☐ Associate Member ☐ Affiliate Member $250

- Full Membership requires that you supervise at least 2 additional coworkers
- Associate Membership is open to any coworkers of a healthcare provider and free with a FULL member
- Affiliate Membership is open to anyone who is in the healthcare industry not an employee of a healthcare provider or a healthcare provider that does not have a full member.

Please direct any membership questions to info@ascomsc.org

☐ Make checks payable to ASCOM and mail to: Association of South Carolina Oncology Managers
Attention: membership
P.O. Box 81
Mt. Pleasant, SC 29464

Please charge my: ☐ AMEX ☐ MasterCard ☐ Visa

Name on Credit Card:____

Credit Card Number: ____ Exp: ________________

Authorized Signature: _____________________________________ CVV:_____________

**Visa/MasterCard/American Express will incur a 3% processing fee

You may e-mail the application to: info@ascomsc.org