Connective Tissue Oncology Society
Application for Membership

PLEASE TYPE INFORMATION

Name _____
First *MI* *Last* *Degree*

Gender _____

Address _____

_____

_____

Phone _____
(include area code, or country and city codes)

E-Mail _____

Institution _____

Please indicate your discipline:

____ Cytogenetics
____ Diagnostic Imaging
____ Hematology/Oncology
____ Medical Oncology
____ Musculoskeletal Oncology
____ Oncology Nursing
____ Oncology Research
____ Orthopaedic Oncology
____ Orthopaedic Surgery
____ Pathology
____ Pediatric Oncology
____ Plastic Surgery
____ Radiation Oncology
____ Radiology
____ Surgical Oncology
____ Other: _____

Dues:
____ $200.00/year for members
____ $100.00/year for Allied Healthcare Professional
____ $50.00/year for residents/fellows Start date: _____ End date: _____

(Please have the chair of your department send a letter with your application stating your position and the beginning and expected completion dates of the residency/fellowship)

____ Check (payable to "CTOS")
____ Credit Card ____ Visa ____ Master Card ____ American Express
Card Number _____
Expiration Date _____ CVV Code _____
Signature _____

Please return completed application (with dues) to:

Barbara Rapp
Executive Director
Connective Tissue Oncology Society
P.O. Box 320574
Alexandria, VA 22320-0611

Phone: (301) 502-7371 / Fax: (703) 548-4882
E-Mail: ctos@ctos.org

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