Florida Society of Clinical Oncology

FLASCO Membership Application

Last Name:			
First Name:			MI:
Academic Degree/s:			**Gender:** F ☐ M ☐
Date of Birth:	FL Medical License No:		Expiration Date:
Practice Type: Private: ☐	Hospital: ☐	Academic: ☐	Other: ☐
Practice/Institution/Academic Center Name:			
Department/Specialty:		Title:	
Street Address:			
City:	State:		Zip Code:
Office Phone No.:		Fax No.:	
Work Email:			
Assistant's Name:		Assistant's Email:	
Home Address:			
City:	State:		Zip Code:
Mobile No.:	Home Email:		
PREFERRED MAILING ADDRESS (circle preference) ☐ Home	Practice/Institution/Organization ☐		
PREFERRED EMAIL ADDRESS FOR COMMUNICATION WITH FLASCO:	Personal: ☐	Work: ☐	
REQUIRED ATTACHMENTS:	CV/Resume: ☐	Scanned Copy of Board Certificates or Equivalents: ☐	
Physicians in Training: Letter of Recommendation ☐	Students: Personal Statement of Interest in Oncology ☐		

PLEASE INDICATE IN WHICH FLASCO COMMITTEE/S YOU HAVE AN INTEREST:
(see requirements and eligibility on FLASCO website):

Board	Program	Membership
Board Appointee	Ethics	Nominating
Clinical Practice	Legislative	Bylaws

PLEASE LIST YOUR OTHER PROFESSIONAL ORGANIZATION MEMBERSHIPS:

PLEASE PROVIDE YOUR USERNAME SO WE CAN CONNECT WITH YOU:

Twitter Handle: Facebook Profile URL: LinkedIn Profile URL:

APPLICANT SIGNATURE: Date:

As a FLASCO Member, you are encouraged to attend at least one meeting/event annually to retain your free membership.

RETURN COMPLETED APPLICATION FORM AND REQUIRED ATTACHMENTS BY MAIL/FAX/EMAIL TO:

Florida Society of Clinical Oncology
10006 Park Place Ave. Riverview, FL 33578 | Office: (813) 677-0246 | Fax: (813) 677-0559 | Email:**info@flasco.org**