

Application for Associate Membership

Individuals that are employed by an oncology hematology practice and are represented by one Active member. (Example: Administrator is the Active member then the billing manager, nurse, and/or purchasing manager would be the Associate members). There is no limit to associate members per practice.

Annual Dues: \$35.00 each

Please mail the signed application and payment to POHMS' Member Services 1802 State Route 31, # 312, Clinton, NJ 08809 ~ Phone: 908-617-5063, ext.304 ~ Fax: 866-631-3299 ~ Visit www.pohms.com

Applicant Information (Please type or print clearly.)

Name			
First		Last	
Title/Position	:		
Please indicat	e:		
MD	PhD	Email Address:	
PharmD	BA	Ziidii Hudi ess.	
	MSN		
	BS		
		Gender:	
Other		□ Male	
		□ Female	
		- Female	
PRACTICI	E INFORMATION	•	
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Active Men	nher of Practice		
Active Men	iber of Fractice		
Practice			
Name			
Address			
Audress			
City		State	Zip/Postal Code



County		
Phone ()	Fax ()	
Member Name (please print):		
Member Signature:	Date:	
Would you be interested in serving of	on a committee or as a POHMS Board Member? Yes No	
	with any questions. A copy of this application will be mailed to you as confirmation of your paid membership.	
Fran Spine Administrative Director 908-617-5063, ext. 304		
For Office Use Only		
Membership Level:		