POHMS
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY
Improving the business conditions of the oncology hematology practice

Application for Active Membership

Active membership is available to individuals having management responsibilities within an oncology hematology practice *(An administrator, office manager, or physician is normally the Active member).*
Annual Dues: $150.00 (must have one per practice)

Please mail the signed application and payment to POHMS' Member Services
1802 State Route 31, # 312, Clinton, NJ 08809 ~ Phone: 908-537-6880 ~ Fax: 866-631-3299 ~
Visit www.pohms.com

Applicant Information (Please type or print clearly.) Please use separate application for Associate Members.

Name_____
First **Last**

Title/Position:_____

Please indicate:
MD **PhD**
PharmD **BA**
RN **MSN**
MS **BS**
Other_____

Email Address:_____

Gender:
o **Male**
o **Female**

PRACTICE INFORMATION:

Practice Name_____

Address_____

_____

_____
City State Zip/Postal Code

_____
County

Phone (_____)_____ **Fax** (_____)_____

Total Practice Employees:_____ **Total # of RN's:**_____

How Long Practice in Existence? _____ **Total # of Physician Extenders:** _____

Physicians:

Please list_____

_____

_____

_____

_____

Additional Sites: **Yes** **No** Please circle one and list addresses if applicable.

Satellite #1:

_____

_____

_____

Satellite #2:

_____

_____

_____

Satellite #3:

_____

_____

_____

Satellite #4:

_____

_____

_____

Please list any additional satellite offices on a separate page and attach to the application.

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Practice Management System _____

AR Tool: EOB One_____ **Other** _____

Pyxis **Yes** **No** **EMR** **Yes** **No**

(Specify)_____

Internet **Yes** **No**

Dial-up DSL High Speed/Cable T1

Practice Website? Yes No

(Specify)_____

Research **Yes** **No** _____

Ancillary Services:

PET/CT Retail Pharmacy Complimentary Therapies

Other(Specify)_____

Practice Type:

Community-based Hospital-owned Hospital-based Multi-specialty

Other (Specify)_____

As a member of the Premier Oncology Hematology Management Society I agree that my practice will be represented at not less than two meetings or events in a year (the annual conference counts as one meeting). I further understand that failure to comply with these membership requirements may result in the revocation of my practice membership. I also understand under these conditions, membership dues are non-refundable.

Member Name (please print): _____

Member Signature: _____ Date: _____

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To help us serve you better please answer the following questions. This information will be maintained in our database for POHMS use only for benchmarking purposes.

1. Number of chemo chairs in your office _____ Beds _____

2. Other ancillary staff: (if more room is needed, please use back of page)

Position _____ Number _____

Position _____ Number _____

Position _____ Number _____

Position _____ Number _____

3. Number of employees in the Billing Department _____ Certified Coders _____

Certification held _____

4. Does your practice have a patient financial counselor? Yes No

5. Does the practice send employees for continued education? Yes No

6. Any particularly skilled staff member? (Ex: Contract Negotiator, Speaker)

_____

7. Other organizations you belong to: MGMA AOHA AAPC AHIMA Other_____

8. Do you have an employee (s) or a physician(s) that is a Board member of an organization?

If yes, what organization _____ Position held _____

9. Other information that may be unique to your practice _____

_____

10. Other Comments:

_____

_____

11. Would you be interested in serving on a committee or as a POHMS Board Member? Yes No

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Thank you for taking the time to answer these questions. Your name will be enrolled in a raffle at the next POHMS meeting your practice attends.

Please do not hesitate to contact me with any questions. A copy of this application will be mailed to you after it is processed which will serve as confirmation of your paid membership.

Fran Spine
Administrative Director
908-537-6880

For Office Use Only

Membership Level: _____

Amount paid: _____ Date: _____

Copy to Member: _____

Signature:

Fran Spine – POHMS Administrative Director