



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: 908-537-6880 ~ Fax: 866-631-3299 ~
Visit www.pohms.com

Applicant Information (Please type or print clearly.)

Name _____
First Last

Title/Position: _____

Please indicate:

MD PhD
PharmD BA
RN MSN
MS BS
Other _____

Email Address: _____

Gender:
 Male
 Female

PRACTICE INFORMATION:

Active Member of Practice: _____

Practice Name _____

Address _____

City State Zip/Postal Code

County

Phone (_____) _____ Fax (_____) _____



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: _____

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

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