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

Please mail the signed application and payment to POHMS' Member Services
1802 State Route 31, # 312, Clinton, NJ 08809 ~ Phone: 908-617-5063 ~ 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:
☐ **Male**
☐ **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:

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____

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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

Satellite #4: ____
____
____

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

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)____

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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

Member Name (please print): ____

Member Signature: ______________________________ Date: ________________________________

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

Thank you for taking the time to answer these questions. Your input is greatly appreciated.

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
908-617-5063, ext 304

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For Office Use Only

Membership Level: ______________________________________

Amount paid: __________________________ Date: ____________________________