APAO ASSOCIATION OF PHYSICIAN ASSISTANTS IN ONCOLOGY
partners in cancer care

❑ New
❑ Renewal

OK to publish all information in Directory? ❑ Yes ❑ No

Name		Designation(s)
*PA School Attended/Attending		*Graduation Date or Expected Graduation Date
*Post-Grad Training Program		*Completion Date or Expected Completion Date
Degree	Years working in Oncology	NCCPA Certification Number
Home Address (□ Check box if this is primary mailing address; otherwise, business address will be set as primary)		
City/State/Zip		Home Phone
Business Phone	Cell Phone	Fax
Email Address By providing your email address, you agree to accept valuable member information sent electronically.		Secondary Email Address
Business Name		Website
Business Address		
City/State/Zip		Referring Member
Oncology Discipline	Sub-Specialty	Practice Setting

Mailing List: APAO periodically provides member contact information to carefully selected organizations to send communications by or on behalf of APAO via regular mail or email. Please check if you wish to be REMOVED from this list ❑

Additional Areas of Support

Please check all volunteer opportunities you would be interested in:

❑ Advocacy / Legislation ❑ Website ❑ CME ❑ Professional Practice Network
❑ Scholarship / Student Outreach ❑ Newsletter ❑ Membership

MEMBERSHIP CATEGORIES: (please check ONE)
Membership runs from date of enrollment.

	Fellow – 1 Year **(AAPA member # required _____)**	$40		Sustaining - 1 Year (Non-AAPA member)	$40		Affiliate – 1 Year	$40
	Fellow – 3 Years **(AAPA member # required _____)**	$100		Sustaining - 3 Years (Non-AAPA member)	$100		Affiliate – 3 Years	$100
	Fellow – Lifetime **(AAPA member # required _____)**	$400		Physician	$60		Associate	$60
				Student ***PA school & graduation date required above. Also applies to students in Post Graduate Fellowship Programs.***				$0

Method of Payment Information:

(Select One) Check #:_____ **Total Amount $** _____

❑ Visa ❑ MasterCard ❑ American Express

Credit Card Number: _____ **Exp. Date:**_____ **CVV**_____

Card Holder Name: _____

Billing Address (if different from mailing address): _____

Authorized Signature (Required): _____

Please make checks payable to APAO and mail to:
APAO Headquarters, 222 S. Westmonte Dr, Ste 111, Altamonte Springs, FL 32714
Telephone: 407-774-7880 FAX (for charge payments only): 407-774-6440 * www.apao.cc

For Administrative Use Only

Date Recd: _____ **Ref #:** _____ **Amount:** _____ **Date Approved:** _____

Revised: 05-2018