



Idaho Society of Clinical Oncology (ISCO)
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Phone: 208-901-3353 Fax: 410-544-4640 | <https://twitter.com/ISCOncology>
<https://www.idSCO.org> • <https://www.facebook.com/IDSCO>

Application for Membership

Please complete the information so we can update our files and make sure our information is accurate, for the website. Only the highlighted information will go on the website.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Medical Oncologist | <input type="checkbox"/> Neuro Oncologist | <input type="checkbox"/> GYN Oncologist | <input type="checkbox"/> Radiation Oncologist |
| <input type="checkbox"/> Hematologist | <input type="checkbox"/> Surgical Oncologist | <input type="checkbox"/> Nurse | <input type="checkbox"/> Radiation Therapist |
| <input type="checkbox"/> Radiologic Technologist | <input type="checkbox"/> Mid-Level Provider | <input type="checkbox"/> Medical Dosimetrist | <input type="checkbox"/> Chemo Nurse |
| <input type="checkbox"/> Practice Administrator | <input type="checkbox"/> Office Manager | <input type="checkbox"/> Business Staff | <input type="checkbox"/> Billing/Coding |
| <input type="checkbox"/> Fellow | <input type="checkbox"/> Resident | <input type="checkbox"/> Other: _____ | |

Name: _____ Degree(s): _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Practice Name: _____
Office Address #1: _____
City: _____ State: _____ Zip: _____ County: _____
Office Phone: _____ Fax: _____
Practice Website: _____ Practice Manger: _____
List of Physicians in Practice: _____

Practice Name #2: _____
Office Address #2: _____
City: _____ State: _____ Zip: _____ County: _____
Office Phone: _____ Fax: _____

Board Certified Yes _____ No _____
Name of Board: _____
AL State License #: _____
Subspecialty(s): _____

**We also need a picture (280x280 or larger) of you for the ISCO Website- please,
email to carol@nextwavegroup.net**

Signature: _____ Date: _____