## Children's Oncology Group

## INTERNATIONAL ASSOCIATE MEMBERSHIP APPLICATION

Title (i.e. Dr., Ms.,)	First Name	Middle Name
Last Name		Degree
Institution Name		
Department/Division		
Street Address		
Street Address (continu	ned)	
City		State or Province
Zip Code or Postal Cod	le	Country
E-mail Address (enter v	with exact letter casing)	
Telephone Number (include Country Code)		Extension
Fax Number (include C	Country Code)	
Discipline (Brief staten	nent of experience in childhood cancer research)	

Clinical Research Interest (Brief description of your interest in COG and how you may be able to collaborate/contribute; use additional pages, if necessary)	
1	
1	Name of COG Full Member - Letter of Support Required
۷	Name of COG Full Member - Letter of Support Required
	3. Applicant's CV or Biosketch Included
	Applicant's Signature
	** Important **
Up	on completion, please return application and documents
	to:
	COC Marchambia Donoutment
	COG Membership Department MembershipInfo@childrensoncologygroup.org
	Phone: (626) 241-1515
	Fax Number: (626) 447-7450
	ARTMENT USE ONLY
Date Received:	
Membership Committe	e Chair:
Group Chair:	
Membership Office No	otes: