Children's Oncology Group

INTERNATIONAL ASSOCIATE MEMBERSHIP APPLICATION

_______________ ____ ______________
Title (i.e. Dr., Ms.,) **First Name** **Middle Name**

____ ______________
Last Name **Degree**

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Institution Name

____
Department/Division

____
Street Address

____
Street Address (continued)

____ _____________________
City **State or Province**

____ ____________________
Zip Code or Postal Code **Country**

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E-mail Address (enter with exact letter casing)

____ ____________________
Telephone Number (include Country Code) **Extension**

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Fax Number (include Country Code)

Discipline (Brief statement of experience in childhood cancer research)

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Clinical Research Interest **(Brief description of your interest in COG and how you may be able to collaborate/contribute; use additional pages, if necessary)**

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1. ____
Name of COG Full Member - Letter of Support Required

2. ____
Name of COG Full Member - Letter of Support Required

3. **Applicant's CV or Biosketch Included**

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Applicant's Signature

**** Important ****

Upon completion, please return application and documents to:

COG Membership Department
MembershipInfo@childrensoncologygroup.org
Phone: (626) 241-1515
Fax Number: (626) 447-7450

MEMBERSHIP DEPARTMENT USE ONLY

Date Received:
Membership Committee Chair:
Group Chair:
Membership Office Notes: