



**Coalition of Hematology Oncology Practices of the Southwest  
(CHOP)**

1001A E Harmony Rd, #264  
Fort Collins, CO 80525  
970-631-5612

[www.choptx.org](http://www.choptx.org)

**2015 Individual Membership Application**

Only one active, voting member per practice. Dues are \$75 for first, voting member of a practice, \$50 for additional members.

Date: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Name (First Middle & Last): \_\_\_\_\_

Job Title: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Practice Information:**

Active  Associate If Associate, Active Member's Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Web Site URL: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Practice Type: Community-based Other: \_\_\_\_\_

Do you have Satellite Offices? No If yes, please complete the List of Satellite offices on back of this form.

How long has the Practice been in Existence? \_\_\_\_\_ Total Practice Employees: \_\_\_\_\_

Total # Mid-level Providers: \_\_\_\_\_ Total # Physicians: \_\_\_\_\_ Total # of Nurses: \_\_\_\_\_

List Physician(s) in practice: \_\_\_\_\_

Radiation Services? No If yes, what type? \_\_\_\_\_ IMRT \_\_\_\_\_ Brachytherapy \_\_\_\_\_ Cyberknife \_\_\_\_\_

Ancillary Services: \_\_\_\_\_ HDR \_\_\_\_\_ Chemotherapy \_\_\_\_\_ PET/CT/MRI \_\_\_\_\_ Other (specify) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**List of Satellite Offices  
(CHOP Active Membership Application)**

Practice Name: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

If space is needed for additional satellite offices, please duplicate this page and attach to application.

**List of Associate Members  
(CHOP Active Membership Application)**

Name (First Middle & Last): \_\_\_\_\_

Job Title: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Name (First Middle & Last): \_\_\_\_\_

Job Title: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

Name (First Middle & Last): \_\_\_\_\_

Job Title: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Satellite Office: \_\_\_\_\_

If space is needed for additional associate members, please duplicate this page and attach to application.