Coalition of Hematology Oncology Practices of the Southwest
(CHOP)
1001A E Harmony Rd, #264
Fort Collins, CO 80525
970-631-5612
www.choptx.org

2015 Practice Membership Application

Only one active, voting member per practice. Dues are $250/year for a practice membership (includes 2 free at the conference and whole practice participation in webinars and list serv). Additional members attending conferences are $50 each.

Date: _____ ☐ **Male** ☐ **Female** **Date of Birth:** _____

Name (First Middle & Last): _____

Job Title: _____ **Email:** _____

Cell Phone: _____

Practice Information:

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: _____

CHOP dues are not deductible as a charitable contribution for federal tax purposes. However, they may be tax deductible as ordinary and necessary business expense subject to restrictions imposed as a result of association lobbying activities. CHOP estimates that the nondeductible portion of your dues-the portion which is allocable to lobbying is less than 5%.
Coalition of Hematology Oncology Practices - Federal Tax ID #260064206 – 501(c)6

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.