



ALLIED MEMBERSHIP APPLICATION

Requirements for Allied Membership Applicants

Allied membership may be conferred by the SGO Council on non-physician specialists who have demonstrated their ability to participate in the care and treatment of patients with gynecologic cancers and who satisfy one of the following qualifications:

QUALIFICATIONS:

- i) Graduation or completion of training from an accredited university training program.
- ii) Certification, registration or licensure by their specific state, national organization or Board of specialty, if applicable.
- iii) Eligible for membership in his or her professional discipline's national association.
- iv) Demonstrated interest in gynecologic oncology practice, research or education.
- v) Adequate experience in caring for women with gynecologic cancers, such experience to be evaluated by the Membership Committee and SGO Council.
- vi) A minimum of one year active practice.

Instructions

1. Complete the enclosed application form and attach the following:
 - a. Application fee of \$25.00 (USD). Checks should be made out to **SGO**.
 - b. Passport size photograph.
 - c. A copy of the certificate or letter from the certifying board verifying board certification.
 - d. One (1) letter of recommendation from an active member of SGO.
 - e. Copy of CV (should include publications and presentations).
 - f. Only completed applications will be accepted.
 - g. Dues in the amount of \$150.00 (USD) will be invoiced upon membership approval.
2. **Failure to follow these guidelines will cause your application to be returned in order to obtain compliance, and may delay approval of your application.**
3. **Main deadline: July 31st**
Applications are accepted throughout the year as needed
4. Send completed applications to:
Society of Gynecologic Oncology
230 W. Monroe Street, Suite 710
Chicago, IL 60606-4703 USA

or e-mail to: membership@sgo.org

PERSONAL INFORMATION

Name	
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth
Place of Birth	
Citizenship	
Title	
Institution	

MAILING ADDRESS

Street	
City	
State/Province	
Country	Postal Code
Phone Number (Country Code + City Code + Number)	
FAX (Country Code + City Code + Number)	
Email	

PROFESSION

- | | |
|---|---|
| <input type="radio"/> Clinical Nurse Specialist | <input type="radio"/> Physician Assistant |
| <input type="radio"/> Genetic Counselor | <input type="radio"/> Practice Management |
| <input type="radio"/> Nurse | <input type="radio"/> Radiation Tech |
| <input type="radio"/> Nurse Practitioner | <input type="radio"/> Research Staff |
| <input type="radio"/> Palliative Care | <input type="radio"/> Social Work |
| <input type="radio"/> Pharmacist | |

PROFESSIONAL DESIGNATION

- | | | | |
|-----------------------------------|---------------------------|------------------------------|--------------------------|
| <input type="radio"/> BS | <input type="radio"/> MS | <input type="radio"/> PA-C | <input type="radio"/> RN |
| <input type="radio"/> BSN | <input type="radio"/> MSN | <input type="radio"/> PharmD | <input type="radio"/> RT |
| <input type="radio"/> CMD | <input type="radio"/> MSW | <input type="radio"/> OCN | |
| <input type="radio"/> Other _____ | | | |

PROFESSIONAL INFORMATION

University/College	
Degree	Date
Graduate School	
Degree	Date
Licensure or Registry	
Number	State
Countries where licensed	
Certification	
Board Certification	
Specialty Certification	

ACADEMIC APPOINTMENTS

1
2

HOSPITAL AFFILIATIONS (provide names and addresses)

1
2
Clinical Practice

HOSPITAL STAFF APPOINTMENTS (provide names and addresses)

1
2

- Any investigations pending? Yes No
- Any license revocations or restrictions? Yes No
- Any felony convictions? Yes No

In furtherance of my application for membership in the Society of Gynecologic Oncology (SGO), I hereby authorize the evaluation and validation of my credentials by SGO in accordance with and subject to the rules and procedures of the SGO.

I request and authorize any hospital, medical staff, medical organization or individual who may have information (including, but not by way of limitation, medical records, patient records, and reports of committees) which they deem relevant to my fitness for membership in SGO to provide such information to SGO.

I hereby release from liability and waive any claim for damages that I may have against SGO, its officers, directors, members, employees and agents for any acts that they may perform in good faith in connection with my application, and any hospital, medical staff, medical organization or individual supplying information with respect to my application.

I understand that the decision as to whether I am qualified to be submitted to SGO membership for election rests solely and exclusively in the SGO Council, and that its decision is final.

I attest that the information presented in this application is truthful and accurate.

Please place photograph here

Signature	Date
-----------	------

PAYMENT METHOD	
<input type="radio"/> Check Enclosed payable to SGO	Please charge my Credit Card <input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> American Express
Name as it appears on card	
Card Number:	
Card Security Code	Expiration Date (MM/YY)
<input type="radio"/> I authorize the use of my credit card for the following charges. <input type="radio"/> Application Fee \$25.00 (USD)	
Card Holder Signature	Date

CREDIT CARD BILLING ADDRESS	
Street	
City	
State/Province	
Country	Postal Code

If you are submitting this form electronically, please attach a digital photo to the e-mail when sending.

