

Membership Application



ASSOCIATION
of CANCER
EXECUTIVES

www.cancerexecutives.org

Membership Benefits

Membership benefits include annual subscription to ACE's bimonthly newsletter *ACE Update*, a Membership Directory, access to the ACE Job Bulletin Board, use of the ACE's ListServ®, participation in the annual meetings at a reduced rate, and the opportunity to contribute leadership talents as elected Board or Committee members.

Membership Categories and Dues

■ Delegate Member \$195

Delegate members must have responsibility for at least one (1) functional oncology diagnostic or treatment area and/or serve the cancer community in a related administrative role. Delegates are encouraged to serve on ACE standing committees. Delegates are entitled to the full benefits of the organization including the right to vote and holding office on the ACE Board.

■ Associate Member \$150

Associate members are those who, for whatever reason, do not meet the criteria for either delegate or corporate membership, but who, at the sole discretion of the Board of Directors, may have reason to contribute value to the organization. Associate members may vote and serve on all committees, but may not hold elected office.

■ Corporate Member \$450

Corporate members who wish to contribute towards the goals of ACE may join the organization. Any organization, group or individual who has goods or services to sell to the membership qualifies for Corporate Membership. Corporate members are encouraged to serve on ACE standing committees. Corporate members are entitled to the full benefits of the organization including the right to vote and hold office on the ACE Board. There may be no more than two (2) Corporate Members on the Board of Directors at any given time.

Apply for Membership

- 1) Complete this application form. Please be sure to type or print neatly using ink.
- 2) Fill in all information exactly as you would like it to appear in ACE listings; sign and date the application.
- 3) Attach a check made payable to ACE in U.S. funds for the appropriate fee, or pay by credit card by completing the information requested. Your application will not be deemed complete and will not be processed until the application fee and all information is received.
- 4) If, for some reason, you are not eligible for ACE membership, your membership dues will be promptly refunded.

Recruited by: _____

Institution: _____

Email Address: _____

I would like an ACE Membership Application forwarded to a friend/colleague. Please send an application to:

Name (first/last) _____

Organization or Employer/Affiliation _____

Address _____

City _____ State _____ Zip _____

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FOR OFFICE USE ONLY	Date Received	Invoice #	Amount Paid: \$
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ACE Membership Application (continued)



Membership Category Applied for: Delegate (\$195) Associate (\$150) Corporate (\$450)

APPLICANT INFORMATION *(Please type or print legibly; list information **exactly** as you would like it to appear in ACE listings)*

Dr. Mr. Ms. Mrs.

First Name _____ Middle Initial _____ Last Name _____

Degrees (check all that apply): BS BA MBA MHS/MHA MD PhD MSN Other _____

Clinical License(s) (check all that apply): RN MD Other _____

Job Title _____ Department _____

Institution/Company Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

E-mail _____

(Your email address is used for access to the membership directory and ensures you will receive vital ACE correspondence, including the ACE Update.)

TYPE OF ORGANIZATION

- | | | |
|--|---|---|
| <input type="checkbox"/> Academic Cancer Center | <input type="checkbox"/> Single Center, Hospital-owned | <input type="checkbox"/> Product/Services Vendor or Consultant (please describe): |
| <input type="checkbox"/> Community Cancer Center | <input type="checkbox"/> Free Standing Center | <input type="checkbox"/> Consultant _____ |
| <input type="checkbox"/> Private or Group Practice | <input type="checkbox"/> Part of a Health System with Multiple-owned Cancer Centers | <input type="checkbox"/> Product Vendor _____ |
| | | <input type="checkbox"/> Service Vendor _____ |
| | | <input type="checkbox"/> Other _____ |

MEMBER BUSINESS INFORMATION

Title of Person to Whom You Report _____

Administrative Role (Cancer): Full Time 75% 50% 25% Less than 25% Other _____

ROLE IN ORGANIZATION

- | | | |
|---|---|---|
| <input type="checkbox"/> Service line administration | <input type="checkbox"/> Patient care management/administration | <input type="checkbox"/> Oncology services across health system |
| <input type="checkbox"/> Academic dept./division administration | <input type="checkbox"/> Multi-center operations | <input type="checkbox"/> Other _____ |

CONSULTING/SALES

- | | | |
|--|---|---|
| <input type="checkbox"/> Reimbursement/Coding Consultation | <input type="checkbox"/> Oncology services across health system | <input type="checkbox"/> Oncology products in addition to other products and services |
| <input type="checkbox"/> Operations/Management Consulting | <input type="checkbox"/> Financial/Contracting consultation | |
| <input type="checkbox"/> Product Sales | <input type="checkbox"/> Other _____ | |

Payment Method *Dues payable in U.S. funds only*

- Check enclosed in the amount of \$ _____
- Please bill by credit card in the amount of \$ _____ American Express MasterCard Visa
- Credit Card # _____ Expiration Date _____ Security ID _____
- Name on card _____ Signature _____

Applicant's Signature: _____ Date _____

SUBMIT APPLICATION TO:

Association of Cancer Executives • 1255 Twenty-Third Street, NW, Suite 200 • Washington, DC 20037-1174 • Fax: (202) 833-3636