



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

8805 North 145th East Ave., Ste 203

Owasso, OK 74055

918-274-8374 Fax: 918-274-8354

www.choptx.org

Active Member Application

Only one per practice. This member is the voting member of the practice. Dues are \$50/year.

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) _____

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%.

FEIN: 26-0064206

**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.