



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

8805 North 145th East Avenue, Suite 203  
Owasso, OK 74055  
(918) 274-8374 Phone (918) 274-8354 Fax  
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  
Gender

\_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix

\_\_\_\_\_ Job Title \_\_\_\_\_ Email Address

\_\_\_\_\_ Cell Phone (optional)

### Practice Information

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

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

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

\_\_\_\_\_ Practice Address Line 2

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

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

**Practice Type:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Do you have any Satellite Offices?** \_\_\_\_\_ **If yes, please complete the List of Satellite Offices**

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

**Total # of Mid-Level Providers:** \_\_\_\_\_ **Total # of Physician:** \_\_\_\_\_ **Total # of Nurses:** \_\_\_\_\_

\_\_\_\_\_ List Physician(s) in Practice

**Radiation Services?** \_\_\_\_\_ **If yes, what type?** \_\_\_\_\_ IMRT \_\_\_\_\_ Brachytherapy \_\_\_\_\_ Cyberknife

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

For more information, please contact CHOP Executive Director, Mary Jo Wichers at (918) 261-8951 or visit [www.choptx.org](http://www.choptx.org).

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

**Practice Name:**

---

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

Practice Address

Practice Address Line 2

City

State

Zip

Office Phone

Office Fax

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

Practice Address

Practice Address Line 2

City

State

Zip

Office Phone

Office Fax

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

Practice Address

Practice Address Line 2

City

State

Zip

Office Phone

Office Fax

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

Practice Address

Practice Address Line 2

City

State

Zip

Office Phone

Office Fax

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