



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

8805 North 145th East Avenue, Suite 203  
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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) \_\_\_\_\_

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%.

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

**Practice Name:**

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**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.**