

# NEW YORK METROPOLITAN BREAST CANCER GROUP, INC.

410 Park Avenue, 15<sup>th</sup> Floor, New York, NY 10022

Phone (212) 752-1965 \* Fax (845) 986-3336 \* nymbcg@gmced.com

www.nymetropolitanbreastcancergroup.org

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## APPLICATION FOR MEMBERSHIP

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Date : \_\_\_\_\_

Name : \_\_\_\_\_  
(Last) (First) (M) (Degree)

Office Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send mail to: Home Office  
(circle one)

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

E-Mail: \_\_\_\_\_  
(used to send our announcements)

Specialty: Breast Surgery Genetic Counselor Hematology Oncology  
(circle one) Medical Oncology PA-Nurse-NP Pathology Psychiatry  
Psychology Radiation Oncology Radiology

Primary Hospital Affiliation: \_\_\_\_\_

Medical School Affiliation: \_\_\_\_\_

Academic Rank: \_\_\_\_\_

% of time Breast Disease clinical practice \_\_\_\_\_

% of time teaching \_\_\_\_\_

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State your special interest in breast cancer and in joining this group:

\_\_\_\_\_  
\_\_\_\_\_

Name of Member who Will Provide Verbal Recommendation for Membership (please print clearly)

\_\_\_\_\_

\*\*\*\*\* Please forward completed application and a copy of your CV to the above address. \*\*\*\*\*

Yearly Membership Dues are \$200