



Application for Membership

Please provide information about yourself in the shaded boxes below.

Date:

Type of Membership:

- Individual
 Organization

First Name:

M.I.

Last Name:

Degrees/Credentials:

Job Title:

Organization or Affiliation:

Address 1:

Address 2:

City:

State:

Zip:

Daytime Phone:

Email:

I am interested in serving on the following Committee(s) or Action Team(s):

- | | |
|--|---|
| <input type="checkbox"/> Prevention | <input type="checkbox"/> Advocacy |
| <input type="checkbox"/> Early Detection | <input type="checkbox"/> Data, Surveillance, & Evaluation |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Communications |
| <input type="checkbox"/> Survivorship | <input type="checkbox"/> Health Disparities |
| <input type="checkbox"/> Palliative & Hospice Care | <input type="checkbox"/> Membership |
| | <input type="checkbox"/> Governance |
| | <input type="checkbox"/> Annual Meeting |

Please tell us about your areas of interest, including current involvement with cancer prevention and control programs or activities

Please print and mail this form, or submit it as an email attachment to:

Patricia Trotta, RN
American Cancer Society
538 Preston Ave
Meriden CT 06450

Patricia.Trotta@cancer.org