



American Brachytherapy Society

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11130 Sunrise Valley Drive, Suite 350, Reston, VA 20191 • 703-234-4078 • 703-234-4147 (fax)

2023 MEMBERSHIP APPLICATION

Name: _____
(Last) (First) (MI) (Degree)

Date of Birth: ___/___/___ Male Female

Contact Information: Home Office
Institution/Dept: _____
Street: _____
City: _____ State, Zip: _____
Country: _____ E-mail: _____
Phone: _____ Fax: _____
Preferred Username: _____ Preferred Password: _____

Membership Type:

Regular – Active (\$335) <input type="checkbox"/>	Physician <input type="checkbox"/>	Board Certified Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Certification: _____	Specialties Prostate: __ LDR __ HDR GYN: __ Cervical __ T&O __ T&R __ Interstitial Breast: __ Interstitial __ Intracavity __ Electronid __ HDR Skin: __ HDR __ Electronic GI: __ Esophagus __ Cholangeo __ Anal Cardiac __ Ocular __ Lung __
	Medical Physicist <input type="checkbox"/>		
Associate (\$125) <input type="checkbox"/>	Dosimetrist <input type="checkbox"/> Nurse <input type="checkbox"/> Technologist <input type="checkbox"/>		
First Year Post Residency (\$110) <input type="checkbox"/>	Membership time frame is valid for 1 year post-residency		
Resident (\$0) <input type="checkbox"/>	Date of Residency: ___/___/___ to ___/___/___		
	Institution: _____ City: _____ State: _____ Zip: _____		
Commercial (\$500) <input type="checkbox"/>	Company _____ Phone: _____ Ext: _____ (Note: Applicant will be contacted for Commercial Membership, please list contact name in space provided above)		

Benefits:

A subscription to <i>Brachytherapy</i> , 6 issues per year	Networking opportunities with leading brachytherapy practitioners
A bi-annual newsletter	CME, CAMPEP and MDCB credits for ABS educational events
Monthly Brachyblast	
Access to the ABS members-only site	
Discounts to all ABS educational events	

Preferred Username: _____ Preferred Password: _____

Dues:

I have included my dues payment of \$ _____. Check #: _____

Please charge my credit card:

American Express Visa Mastercard

Card #: _____ Expiry: ___/___/___ CVV: _____

Signature (Credit card authorization): _____ Date: ___/___/___

I support the above reference applicant for membership into the Society

Peter J. Rossi, MD, FABS
President, 2022-2023