American Brachytherapy Society

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

2024 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:

<table>
<tr><td rowspan="2">Regular – Active ($335) ☐</td><td>Physician ☐</td><td rowspan="3">Board Certified
Yes ☐
No☐
Date of Certification:

__________</td><td rowspan="3"><u>Specialties</u>
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 __</td></tr>
<tr><td>Medical Physicist ☐</td></tr>
<tr><td>Associate ($125) ☐</td><td>Dosimetrist ☐
Nurse ☐
Technologist ☐</td></tr>
<tr><td>First Year Post Residency ($110) ☐</td><td>Membership time frame is valid for 1 year post-residency</td></tr>
<tr><td rowspan="2">Resident ($0) ☐</td><td colspan="3">Date of Residency: ____ /____/_______ to ____/____/_______</td></tr>
<tr><td colspan="3">Institution: ____
City: ____
State: _____________ Zip: _______________</td></tr>
<tr><td>Commercial ($500) ☐</td><td colspan="3">Company __________________Phone: ____________________ Ext: ________
(Note: Applicant will be contacted for Commercial Membership, please list contact name in space provided above)</td></tr>
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Benefits:

A subscription to *Brachytherapy*, 6 issues per year
Access to the ABS members-only site
Monthly Webinars
Discounts to all ABS educational events

Networking opportunities with leading brachytherapy practitioners
CME, CAMPEP and MDCB credits for ABS educational events

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

____

Brett Cox, MD
ABS President
2023-2024