



American Brachytherapy Society

# American Brachytherapy Society

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

## 2022 MEMBERSHIP RENEWAL 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: _____	<b>Specialties</b> 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 *Brachytherapy*, 6 issues per year  
A bi-annual newsletter  
Monthly Brachyblast  
Access to the ABS members-only site  
Discounts to all ABS educational events  
Networking opportunities with leading brachytherapy practitioners  
CME, CAMPEP and MDCB credits for 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: \_\_\_\_/\_\_\_\_  
Signature (Credit card authorization): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I support the above reference applicant for membership into the Society**

Firas Mourtada, PhD  
President, 2020-2021

Jarek Hepel, MD and Juanita Crook, MD  
Chairs, Membership Committee, 2020 -2021