



American Brachytherapy Society

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

2020 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 (\$315) <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 __ Cholangio __ 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

Dan Petereit, MD, FASTRO
President, 2019-2020

Jarek Hepel, MD and Juanita Crook, MD
Chairs, Membership Committee, 2019 -2020