



Membership Application

AACE Federal ID No.: 52-1484376

1. Print or Type Your Name, Address & Contact Information

Full name and credentials for membership certificate (*Institutional members enter company info here & Rep. info on pg. 2)

Address line 1

Address line 2

City, State / province

Zip / postal code, Country

Phone

Fax

E-mail

2. Choose Two Special Interest Sections from the list below

- | | 1 st | 2 nd |
|--|--------------------------|--------------------------|
| EE Cancer Education Evaluation & Methods | <input type="checkbox"/> | <input type="checkbox"/> |
| PV Cancer Prevention Education..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CO..... Communication in Cancer Care | <input type="checkbox"/> | <input type="checkbox"/> |
| GP..... Graduate & Postgraduate Cancer Education | <input type="checkbox"/> | <input type="checkbox"/> |
| IN International Cancer Education | <input type="checkbox"/> | <input type="checkbox"/> |
| OR..... Oral Cancer Education | <input type="checkbox"/> | <input type="checkbox"/> |
| PC..... Palliative Cancer Education..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PS Psychosocial Cancer Education | <input type="checkbox"/> | <input type="checkbox"/> |
| PP Public & Patient Education | <input type="checkbox"/> | <input type="checkbox"/> |
| PD..... Predoctoral Cancer Education..... | <input type="checkbox"/> | <input type="checkbox"/> |

3. Submit Your Membership Dues

Select your membership category:

- Individual**\$245
- Institutional ***\$695
(Includes 3 representatives – enter on pg. 2)
- Senior**\$65
(Over age 65)

Student Associate

- With subscription to JCE\$65
- Without subscription to JCE\$20

Amount Enclosed USD \$ _____

JCE = Journal of Cancer Education

4. I agree that I will abide by the constitution and bylaws of the AACE

Signature of Applicant: _____ Date: _____

5. Send ① completed application form and ② check made out to AACE or Credit Card Info. for membership dues to

Paula Frampton-Brown
AACE National Office
C/o San Diego Hospice & Palliative Care
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San Diego, CA 92103-1407
USA

Toll-free: +1 (866) 678-2223 Canada & USA
Direct: +1 (619) 278-6164
Fax: +1 (619) 298-7027
E-mail: pbrown@sdhospice.org

- Visa
- MasterCard
- American Express
- Discover

Card Number: _____ Expire Date: _____ / _____

Name as it Appears on Card: _____ Billing Address Zip Code: _____

Authorized Signature: _____ Print Your Name: _____

NAME OF REFERRING AACE MEMBER/SECTION (IF APPLICABLE) _____



**** For Institutional Membership Only**

Representative #1

Full name and credentials

Address line 1

Address line 2

City, State / province

Zip / postal code, Country

Phone

Fax

E-mail

Representative #2

Full name and credentials

Address line 1

Address line 2

City, State / province

Zip / postal code, Country

Phone

Fax

E-mail

Representative #3

Full name and credentials

Address line 1

Address line 2

City, State / province

Zip / postal code, Country

Phone

Fax

E-mail