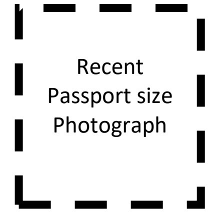
PSPO

Pakistan Society of
Pediatric Oncology

PAKISTAN SOCIETY OF PEDIATRIC ONCOLOGY (PSPO)

MEMBERSHIP FORM

(Please go through Membership Details before completing this form)



Membership #: ____________
(To be completed by PSPO Secretariat)

First Name: ______________ Middle Name: ______________ Last Name: _________________

Gender: ______________ Date of Birth: ______________ PMDC #: _________________

Email Address: _________________________________ Country of Residence: _____________________

Residential Address (Pakistan): ____

Residential Address (Abroad): ____

Specialty: ______________ Designation: __________________ Other (specify): _____________

Institution: ____ Office Tel #: _____________________

Office Address: ____

Graduation: ______________ Institution: ________________________________ Year: ________

Post-graduation: __________ Institution: ________________________________ Year: ________

Membership of other Professional Organizations:

☐ SIOP ☐ CCLG ☐ ASPHO ☐ ASH ☐ Others: ____________________

Interests (Tick where applicable):

☐ Hematological Malignancies	☐ Supportive Care	☐ Infection Control
☐ Stem Cell Transplantation	☐ Benign Hematology	☐ Solid Tumors
☐ Brain Tumors	☐ Twinning	☐ Late Effects
☐ Training/Education	☐ Research	☐ Cancer Registry
☐ Healthcare Quality		

I fully understand & agree:

- To comply with / support PSPO Constitution & Byelaws
- That continuation of my membership will require my ongoing commitment & active contribution to the activities of PSPO.

Signature of Applicant: _________________ Mobile #: ____________________ Date: _____________

For Office Use Only:

Membership Type: ☐ Full ☐ Associate ☐ Student

Membership Approved: ☐ Yes ☐ No (If No, please state reason: _____________________)

_________________ Treasurer

_________________ President

_________________ Gen. Secretary

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