



COG Membership Form: International Associate Membership Application

Title	First Name	Middle Name

Last Name	Degree

Institution Name

Department/Division

Street Address

City	State or Province

Zip Code or Postal Code	Country

E-mail Address <i>(enter with exact letter casing)</i>

Telephone Number <i>(include Country Code)</i>	Extension

Fax Number <i>(include Country Code)</i>

Discipline <i>(Brief statement of experience in childhood cancer research)</i>

Clinical Research Interest <i>(Brief description of your interest in COG and how you may be able to collaborate/contribute; use additional pages, if necessary)</i>

1. Name of COG Full Member - Letter of Support Required

2. Name of COG Full Member - Letter of Support Required

3. Applicant's CV or Biosketch Included

**** Important ****
Upon completion, please return application and documents to:
COG Membership Department
MembershipInfo@childrensoncologygroup.org
Phone: (626) 241-1515
Fax Number: (626) 447-7450

MEMBERSHIP DEPARTMENT USE ONLY

Date Received:
Membership Committee Chair:
Group Chair:
Membership Office Notes: