APAO ASSOCIATION OF PHYSICIAN ASSISTANTS IN ONCOLOGY
partners in cancer care

APAO Volunteer Form

Part I: Personal Information

Name (First, Middle, Last): _____

Phone Number: _____ **Email Address:** _____

Employer: _____ **Secondary Email:** _____

Oncology Discipline/ Specialty: _____

Part II: APAO Committees/ Initiatives

Yes, I am interested in volunteering with APAO, and I would like more information about the following committee(s) and/or initiatives: (*circle all that apply and rank 1-3 in order of preference, if applicable*)

Membership *Scholarship* *Website/ Newsletter* *Education*

Student Outreach *Advocacy/ Legislative* *Conference Planning*

PA Representative/ collaboration with _____ (specify) oncology/ PA/ MD organization or group

Part III: APAO Professional Practice Networks

Yes, I am interested in joining a professional practice network with other PAs in oncology.

1. *Hospital/ Academic Center* *Name of Institution:* _____
2. *Community Oncology* *State or Geographic Region:* _____
3. *Oncology Discipline or Specialty* *Please specify:* _____

Comments: _____

_____

For more information, please refer to the APAO website at www.apao.cc, and feel free to contact us.