

615 Chestnut Street | 17th Floor | Philadelphia, PA 19106-4404 | 215-440-9300 Telephone | 866-423-3965 Toll Free | 267-765-1078 Fax | membership@aacr.org

Section 1: Application Information

Check one of the following boxes if this application is being submitted between September 1 and December 31.

(If dues are applied to the forthcoming year, the membership will take effect on January 1, but the candidate will not be eligible to sponsor an abstract for presentation at the Annual Meeting in March or April of that year.)

The enclosed payment should be applied to the **Current Year** **Forthcoming Year (ineligible to sponsor an abstract for upcoming Annual Meeting)**

Section 2: Candidate Information (Please type or print clearly)

Last/Family Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (mm/dd/year): _____ Title and Dept.: _____

Institute/Company: _____

Division: _____

Academic Degrees Indicate highest degree earned, year earned, and institution granting the degree. (Indicate multiple degrees as appropriate, i.e., MD, PhD)

Doctoral (M.D, PhD, etc.) _____

Master (MS, MA, etc.) _____

Bachelor (BA, BS, etc.) _____

Associate (AA, AS, etc.) _____

Other (RN, JD, etc.) _____

Section 3: Contact Information (Please type or print clearly)

Institute/Company Mailing Address Preferred mail

Street Address: _____ Building/Room: _____

City: _____ State: _____

Zip or Postal Code: _____ Country: _____

Telephone (include area code): _____ Cell/Mobile: _____ Fax (include area code): _____

Email: _____

Home Mailing Address Preferred mail

Street Address: _____ Building/Apt.: _____

City: _____ State: _____ Zip or Postal Code: _____

Telephone (include area code): _____ Cell/Mobile: _____ Fax (include area code): _____

Email: _____

Section 4: Scientific Research

Major Focus (Please check only one)

Advocacy Basic Science Behavioral Science Business Development Clinical Practice Population Science Research Administration Science Education Translational Research

Other (please specify) _____

Research Areas of Expertise/Interest (Please check only one)

<input type="checkbox"/> Behavioral Science	<input type="checkbox"/> Cell Biology	<input type="checkbox"/> Epigenetics	<input type="checkbox"/> Immunology and Immuno-oncology	<input type="checkbox"/> Radiation Science and Medicine
<input type="checkbox"/> Biochemistry and Biophysics	<input type="checkbox"/> Chemistry	<input type="checkbox"/> Experimental and Molecular Therapeutics	<input type="checkbox"/> Molecular Biology	<input type="checkbox"/> Surgical Oncology
<input type="checkbox"/> Biostatistics	<input type="checkbox"/> Clinical Research/Clinical Trials	<input type="checkbox"/> Genetics	<input type="checkbox"/> Pathology	<input type="checkbox"/> Survivorship Research
<input type="checkbox"/> Bioinformatics and Computational Biology	<input type="checkbox"/> Diagnostics and Biomarkers	<input type="checkbox"/> Genomics/Proteomics/-Omics	<input type="checkbox"/> Pediatric Oncology	<input type="checkbox"/> Systems Biology
<input type="checkbox"/> Cancer Disparities Research	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Geriatric Oncology	<input type="checkbox"/> Pharmacology	<input type="checkbox"/> Tumor Biology
<input type="checkbox"/> Carcinogenesis	<input type="checkbox"/> Epidemiology	<input type="checkbox"/> Hematology	<input type="checkbox"/> Prevention Research	<input type="checkbox"/> Virology
<input type="checkbox"/> Other (please specify) _____				

Section 5: Demographic Information

Information concerning gender and ethnic background is solicited to enable the Association to ensure its programs are appropriately serving all members of the cancer research community.

Race or Ethnic Background (Please check only one)

African American/Black Asian Caucasian Hispanic Native American Native Pacific Islander Other

Gender Male Female

Section 6: Member Categories (Select the membership category in which you wish to be reinstated.)

Active: *\$315

Annual dues for Active Members located in countries with emerging economies have been set as follows:

Lower Income - \$20 Lower Middle - \$30 Upper Middle - \$50

Active membership includes an online subscription to **one** AACR journal. Please select below.

Cancer Discovery *Cancer Epidemiology, Biomarkers & Prevention*
 Cancer Immunology Research *Cancer Prevention Research* *Cancer Research*
 Clinical Cancer Research *Molecular Cancer Research* *Molecular Cancer Therapeutics*

Associate: *\$0 No annual dues required.

Graduate Student Medical Student Resident Clinical Fellow
 Postdoctoral Fellow

Affiliate: \$135 (Annual dues for Advocates and Survivors have been set at \$75.)

Student: *\$0 No annual dues required.

Undergraduate Year of Study _____ Date of Expected Graduation _____
 High School Year of Study _____ Date of Expected Graduation _____

Section 7: Association Groups If you belonged to or wish to join any of the following Association Groups, please check the appropriate box(es).

Constituencies	Scientific Working Groups (additional fees may apply-see below)
<input type="checkbox"/> Minorities in Cancer Research (MICR)	<input type="checkbox"/> Behavioral Science in Cancer Research (BSCR)
<input type="checkbox"/> Women in Cancer Research (WICR)	<input type="checkbox"/> Chemistry in Cancer Research (CICR)
	<input type="checkbox"/> Cancer Immunology (CIMM)
	<input type="checkbox"/> Molecular Epidemiology (MEG)
	<input type="checkbox"/> Pediatric Cancer (PCWG)
	<input type="checkbox"/> Radiation Science and Medicine (RSM)
	<input type="checkbox"/> Tumor Microenvironments (TME)

Section 8: Reason for Lapse in Membership

Oversight Lack of funding/cost Relocation Administrative error Missed Reminders Other _____

Section 9: Method of Payment Payment of the current year's dues must accompany this Reinstatement form. See above categories for dues amounts.

Check or Money Order enclosed payable to American Association for Cancer Research, in U.S. Currency, drawn on a U.S. bank.

VISA MasterCard American Express

Total Payment Amount \$ _____

Card Number _____ CVV _____ Expiration Date _____

Signature _____

Send curriculum vitae, bibliography, and membership dues to:
AACR, 615 Chestnut Street, 17th Floor
Philadelphia, PA 19106-4404 or
email to membership@aacr.org with a subject heading
"Membership Reinstatement Application" or fax to 215-440-9412.
myAACR.aacr.org

FOR OFFICE USE ONLY:

2019

DR: _____ DP: _____ DS: _____

DA: _____ DT: _____