

## AACR MEMBERSHIP RESIGNATION REQUEST FORM

### RESIGNATION REQUEST

Name: \_\_\_\_\_ Member ID No.: \_\_\_\_\_ Member Type: \_\_\_\_\_

Join Date: \_\_\_\_\_ Paid-Thru Date: \_\_\_\_\_ Years a Member: \_\_\_\_\_

#### Reason:

- |  |  |
|--|--|
| <input type="checkbox"/> Cutting Back on Society Memberships                     | <input type="checkbox"/> No Longer Interested in AACR Membership |
| <input type="checkbox"/> Changed Fields and No Longer Engaged in Cancer Research | <input type="checkbox"/> Personal Financial Constraints          |
| <input type="checkbox"/> Company Out of Business (Industry)                      | <input type="checkbox"/> Taking Time Off to Raise Children       |
| <input type="checkbox"/> Insufficient Grant Funding                              | <input type="checkbox"/> Unemployed                              |
| <input type="checkbox"/> Membership Dues No Longer Paid by Institute             | <input type="checkbox"/> Retired                                 |
|  | <input type="checkbox"/> Other                                   |

Eligible for Emeritus: Yes  No

Offered Emeritus: Yes  No  N/A

Additional Information: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### CONTACT INFORMATION

Title/Dept.: \_\_\_\_\_

Institute/Company: \_\_\_\_\_

Division: \_\_\_\_\_

Address: \_\_\_\_\_

Address (cont.): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

E-mail: \_\_\_\_\_

#### NOTES:

#### For Office Use Only

Accept Resignation: \_\_\_\_\_

Offer Transfer: \_\_\_\_\_

Other: \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_