

Cancer Liaison Physician Membership Application Form

Date _____ Hospital Identification Number _____

Hospital Name _____

Address _____

City _____ State _____ Zip _____

Telephone (____) _____ Fax (____) _____

Cancer Program Administrator[^]

Name _____ Phone (____) _____ Email _____

Cancer Committee Chair[^]

Name _____ Phone (____) _____ Email _____

Cancer Registrar[^]

Name _____ Phone (____) _____ Email _____

Former Cancer Liaison Physician

Name _____ Address _____

City _____ State _____ Zip _____

Recommended Cancer Liaison Physician (required)

Name _____

FACS

Credentials

Address _____

City _____ State _____ Zip _____

Telephone (____) _____ Fax (____) _____

***Email (required)** _____ Medical Specialty _____

Please note reasons for appointment below:

- | | |
|--|---|
| <input type="checkbox"/> <i>New Program</i> | <input type="checkbox"/> <i>Reappointment</i> |
| <input type="checkbox"/> <i>Expiration of CLP term</i> | <input type="checkbox"/> <i>CLP felt the role was too much responsibility</i> |
| <input type="checkbox"/> <i>CLP moved</i> | <input type="checkbox"/> <i>CLP was unable to commit sufficient time</i> |
| <input type="checkbox"/> <i>CLP retired</i> | <input type="checkbox"/> <i>CLP did not meet cancer program expectations</i> |
| <input type="checkbox"/> <i>Leadership change needed</i> | <input type="checkbox"/> <i>Adding a second Cancer Liaison Physician</i> |
| <input type="checkbox"/> <i>Other:</i> _____ | |

Cancer Committee Chair Signature

Please return to:

Carolyn Jones, Cancer Liaison Program Coordinator
American College of Surgeons
Phone: 312.202.5183
Fax: 312.202.5009

*Please note that the CoC requires that each Cancer Liaison Physician have a working email address.
Appointments will not be processed unless one is provided.

[^] Information required for processing.



A multidisciplinary program of the
American College of Surgeons