PHYSICIAN MEMBERSHIP PROGRAM
JOIN BY MAIL

THE SKIN CANCER FOUNDATION'S PHYSICIAN MEMBERS ARE AT THE HEART OF EVERYTHING WE DO.

I wish to join The Skin Cancer Foundation's Physician Membership Program at the level indicated below:

- ☐ $2,500 **Amonette Circle**
- ☐ $1,000 **Mission Fund**
- ☐ $1,000 **Robins Fund** (For physicians who are fellowship-trained and/or board-certified in Mohs surgery)

MEMBER INFORMATION

Physician First Name | Physician Last Name | Suffix

Practice Name

Practice Address | Address Line 2

City | State | Zip Code

Email Address | Phone Number

ATTESTATION

We reserve the right to deny membership to physicians who don't meet our standards for professional conduct.
You must accept our terms to join our membership program.

☐ I attest that I am a licensed physician, my accreditations are in good standing and I have no criminal history. I understand that my membership may be terminated, and I may be asked to cease using the Foundation's name, logo and other branding in my marketing materials.

PAYMENT INFORMATION

☐ I have enclosed a check made payable to: The Skin Cancer Foundation

Charge my credit card: ☐ American Express ☐ MasterCard ☐ Visa

Cardholder Name

Card Number | Exp. Date | Security Code

Billing Address (If different from practice address) | Address Line 2

City | State | Zip Code

Signature

PLEASE COMPLETE THIS FORM AND MAIL TO:
The Skin Cancer Foundation
205 Lexington Avenue, 11th Floor
New York, NY 10016

CONTACT:
membership@skincancer.org
212.725.5176