

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 physician	s who are fellowship-trained an	d/or board-certified in	Mohs surgery)
MEMBER INFO	RMATION			
Physician First I	Name	Physician Last Name		Suffix
Practice Name				
Practice Addre	SS	Addre	ss 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.				
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PLEASE COMPLETE THIS FORM AND MAIL TO The Skin Cancer Foundation 205 Lexington Avenue, 11th Floor Naw York, NY 10016