Membership Application

Name In Full: ____
(PLEASE PRINT)

Discipline:
- ❑ Gynecology
- ❑ Radiation
- ❑ Medical
- ❑ Nurse
- ❑ Pathology
- ❑ Research Science
- ❑ Radiology
- ❑ Fellow In Training
- ❑ Palliative Care
- ❑ Other (specify) ______________________________

Professional Title In Full: ____

Office Address: ____

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Phone: ______________________ Fax: ______________________
(INCLUDE COUNTRY & CITY CODE) (INCLUDE COUNTRY & CITY CODE)

Email: ____

Please return application and brief resume (1-2 paragraphs) to:

IGCS
P.O. Box 6387
Louisville, KY 40206 USA
001.502-891-4460 tel
001.502-891-4461 fax
adminoffice@igcs.org