



Membership Application

MEDICAL ORGANIZATION or FACILITY

National Consortium of Breast Centers, Inc.
PO Box 1334, Warsaw, IN 46581-1334

Please accept our invitation to become a member of NCBC. Complete this form and mail it with payment to the NCBC office. Payment may be made by check, money order, Visa, MasterCard, Discover or American Express. Upon receipt of this information, your membership certificate and membership materials will be sent to you.

SITE MEMBERSHIP - Medical Organization or Medical Facility

The entity must be a direct provider of patient care. Membership materials, which include membership certificates and Internet listings, will be under the facility/institution/practice name. One individual is designated as the initial or primary member. Subsequent individuals from the same facility may become members at a reduced rate. All memberships include reduced registration to the Annual National Interdisciplinary Breast Conference.

Membership Sponsorship

This Membership was referred- the sponsor's information is listed below

<i>First Name</i>	<i>Last Name</i>	<i>Sponsor NCBC ID</i>
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This Membership was not referred

Contact Information

Name _____

First	M. Initial (if used)	Last	Professional Initials (MD, RN, RT, PhD)
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Title/Position _____

Specialty _____

Department _____

Facility Name _____

Facility Street Location Address _____

Facility Mailing Address if different from Street Address _____

City, State, Zip _____

Business Numbers for General Public/Clients:

Direct Numbers of Applicant

Voice _____

Fax _____

Website _____

Facility or Staff Picture - Please provide if possible - This picture will appear on your Internet Listing

Identify area(s) about which you would be willing to share your expertise

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Policy and Procedures Manual <input type="checkbox"/> Staff Roles and Job Descriptions <input type="checkbox"/> Administrative Software <input type="checkbox"/> Tracking Software <input type="checkbox"/> Breast Center Physical Settings <input type="checkbox"/> Starting a Breast Center <input type="checkbox"/> Expanding a Breast Center to a Women's Center <input type="checkbox"/> Marketing Techniques <input type="checkbox"/> Machinery and Equipment Purchase/Feasibility <input type="checkbox"/> Merging Facilities/Buyouts - Patient Impact <input type="checkbox"/> Merging Facilities/Buyouts - Administrative/Operation Impact <input type="checkbox"/> Other areas of expertise: _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Clinical Pathway Development <input type="checkbox"/> Mobile Mammography <input type="checkbox"/> Patient Educational Resources <input type="checkbox"/> Lymphedema Programs <input type="checkbox"/> High Risk Programs <input type="checkbox"/> Outreach programs <input type="checkbox"/> Clinical Trials <input type="checkbox"/> Breast Reconstruction <input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Nutritional Counseling/Information <input type="checkbox"/> Psycho-social services/programs <input type="checkbox"/> Other areas of expertise: _____ |
|--|--|

Patient Services - This information will appear on your Internet Listing		
<p>Mobile Mammography</p> <p><input type="checkbox"/> Provided <input type="checkbox"/> Not provided Number of units (sites) _____</p> <p>Self-Referrals Accepted ___ yes ___ no</p> <p>Diagnostics</p> <p><input type="checkbox"/> fine needle (FNA) <input type="checkbox"/> core biopsy <input type="checkbox"/> sonography <input type="checkbox"/> ultrasound <input type="checkbox"/> stereotactic <input type="checkbox"/> galactography <input type="checkbox"/> scintimammography <input type="checkbox"/> osteoporosis testing <input type="checkbox"/> MRI Guided Needle Biopsy</p> <p>Rehabilitation</p> <p><input type="checkbox"/> Lymphedema program <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Prosthesis Fitting</p>	<p>Other services for women offered on site</p> <p><input type="checkbox"/> Coordination of pre-natal services <input type="checkbox"/> Coordination of ob/gyn services <input type="checkbox"/> Coordination of osteoporosis services <input type="checkbox"/> Coordination of preventative services <input type="checkbox"/> Participate in clinical trials</p> <p>Interdisciplinary Breast Team</p> <p><input type="checkbox"/> Hold Multidisciplinary Breast Conference <input type="checkbox"/> Holds Weekly Prospective Breast Conference <input type="checkbox"/> Has Certified Breast Patient Navigator On Site <input type="checkbox"/> Has Certified Clinical Breast Examiner On Site</p> <p>Certifications/Accreditations</p> <p><input type="checkbox"/> NQMCB <input type="checkbox"/> NAPBC <input type="checkbox"/> BICOE</p> <p>Treatment</p> <p><input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation therapy</p>	<p>Patient Education</p> <p><input type="checkbox"/> High Risk counseling <input type="checkbox"/> Patient Resource literature <input type="checkbox"/> Patient Resource library/dedicated area <input type="checkbox"/> Complementary and Alternative medicine <input type="checkbox"/> Life Styles <input type="checkbox"/> Nutrition counseling <input type="checkbox"/> Psychosocial counseling <input type="checkbox"/> Patient educator on staff <input type="checkbox"/> Patient Advocacy and Survivorship Groups <input type="checkbox"/> Coordinate Social Service options for patients</p> <p>Surgical</p> <p><input type="checkbox"/> Reconstructive surgery <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Sentinel Lymph node mapping and biopsy <input type="checkbox"/> Ductal Lavage for high risk women</p>
<div style="border: 1px solid black; background-color: #f0f0f0; padding: 10px; margin: 10px auto; width: 80%;"> <p>This is for office use only – IT WILL NOT APPEAR IN ANY LIST OR ON THE INTERNET</p> <p>Approximate number Screening Mammograms performed annually _____</p> <p>Approximate year facility opened _____</p> </div>		

Facility Description

This information will appear on your Internet Listing
 Please provide a description of your facility. (I.e., practice setting, ownership, services provided, staff) The description you provide will be included on your Internet listing. You may attach or e-mail copy if more space is needed.

Membership Networking

Yes No Would you be willing to prepare an article or be interviewed and have our writer prepare an article about your breast center or its programs to be included in a future copy of the NCBC newsletter, the *Breast Center Bulletin*?

Payment Options

Dues Payment Schedule:

-- Membership is from October 1 through September 30

-- Payments received between October 1 and February 28, from all new member applicants, cover membership through September 30 and are at the annual dues rate. **Annual dues are \$250 for the facility and designated member.** Additional applicants from the facility are at the annual rate of \$90 per applicant.

-- Payments received between March 1 and May 31, from new member applicants, cover membership through September 30 and are at the rate of \$125 for initial applicant (facility and designated member) and \$50 for each subsequent applicant.

-- Payments received after June 1 and before September 30, from new member applicants, will be at the annual dues rate and will cover the remainder of that year and all of the next year.

Your Two Membership Certificates will contain one with your facility name only and the other with both your name and the name of your facility

Paying by check
 Paying by Visa, MasterCard, Discover or American Express (complete below)

Card Number _____

Exp. Date _____ CVV2#: _____

Name as it appears on card _____

Charge amount authorized \$ _____

Signature _____

Date of Application _____