The Multinational Association of Supportive Care in Cancer recognize the important and critical role that Patient Partners and advocates have in helping people with cancer and their caregivers with the management of symptoms and the side effects of their treatments.

**Annual Meeting Registration as a Patient Partner:**

To qualify for “Patient Partner” status for membership, individuals must work or volunteer for a recognized cancer patient advocacy organization.

*\*Patient advocacy work in this context is defined as providing input to programs, services, information, and/or support for people affected by cancer. The organization should have a non-professional membership and must not offer continuing medical education (CME) or scientific programs for professionals.*

*NB: Applicants that qualify as both a patient partner AND healthcare professional, researcher or scientist are not eligible for this membership category.*

**Application process:**

When completing your registration form, please include:

1. An outline of your role, experience, and activities as a Patient Partner (Template Part 1)
2. Details of an authorized person\*\* to verify your role as a Patient Partner (Template Part 2)

**Review process:**

Your submission will be reviewed, and you may be asked to provide further information to ensure that you qualify as a Patient Partner.

For anyone wishing to add a MASCC Membership as a Patient Partner, please see below for the associated Annual Membership Dues:

* $20 (1-year membership with online access to the *Supportive Care in Cancer* journal)
* $35 (2-year membership with online access to the *Supportive Care in Cancer* journal)

\*\**An authorized person is a person able to support your status and contribution in capacity as a Patient Partner for the purposes of this membership application. They may include a supervisor, committee Chair, senior member of the host organization for which work is carried out, volunteer coordinator or member of the health care team.*

**MASCC– Patient Partner Membership Application Part 2 of 2**

To be completed **by Authorized Person Supporting the Applicant**.

|  |  |  |
| --- | --- | --- |
| **Applicant Details** | | |
| Full Name |  | |
| Contact Number |  | |
| Email |  | |
| **Authorized Person Supporting this Application** | | |
| Full Name |  | |
| Job Title |  | |
| Organization |  | |
| Organization’s Website or social media profiles (optional) |  | |
| Contact Number |  | |
| Email |  | |
| Relationship to the Applicant |  | |
| **Please list the responsibilities the applicant has in their role as a Patient Partner?** | | |
|  | | |
| **I validate that the applicant is a Patient Partner as outlined by MASCC,** [**linked here**](https://mascc.org/annualmeeting2023/registration/)**.** | | |
| Print Name | |  |
| Date | |  |