Breast cancer is the most commonly diagnosed cancer in women in the United States and will account for approximately 212,000 new cancer cases this year. Because of increased awareness and access to screening mammography, most of these breast cancers will be diagnosed in the earliest stages of the disease. Breast cancers that are confined to the breast at diagnosis are highly curable, with a five-year survival of 98%. Even with disease that has spread to axillary lymph nodes, the five-year survival is 80%. The treatment of early breast cancers usually involves a combination of multiple modalities – surgery, chemotherapy, radiation therapy, and hormone therapy. Surgery is usually the first step, involving mastectomy or lumpectomy with axillary dissection. Depending on the characteristics of the breast cancer at diagnosis, chemotherapy may be offered. Chemotherapy is followed by radiation therapy in women who have breast conserving surgery. Women with estrogen and/or progesterone-positive breast cancer are treated with hormone therapy either as a primary modality or following chemotherapy. A woman’s menopausal status determines the type of hormone therapy prescribed. This review will discuss the latest advances in adjuvant hormonal therapy for breast cancers.

For decades, tamoxifen was the standard adjuvant therapy for hormone-sensitive operable breast cancer. Women received 20 mg daily for five years, substantially reducing the risk of disease recurrence and death. Tamoxifen is still prescribed in this fashion for most women with pre-menopausal breast cancers.

Efforts to improve outcomes in post-menopausal women – the main population with receptor-positive breast cancer – have recently focused on the use of aromatase inhibitors (AIs), which suppress estrogen production. A number of adjuvant clinical trials in the U.S. and Europe investigated AIs in several treatment strategies: as initial therapy for five years, sequencing with tamoxifen after two to three years for a total of five years of hormone therapy, and extended therapy after five years of tamoxifen.

**Initial Therapy for Five Years**
These clinical trials evaluated tamoxifen and AIs in head-to-head comparisons. The first reported trial, the ATAC (Arimidex, Tamoxifen Alone or in Combination) trial, randomized women to receive either anastrozole or tamoxifen alone or the combination of anastrozole and tamoxifen. There was no statistical difference between the combination arm and the tamoxifen alone arm. The anastrozole arm showed a continued disease free survival advantage over the other arms (now with updated data at 68 months). The anastrozole arm also showed a 58% reduction in invasive contralateral breast cancers.

The BIG-198 trial was designed to evaluate the benefits of an initial AI vs tamoxifen and the benefit of switching agents after two years of therapy. The study had four arms – a letrozole for five years arm, a tamoxifen for five years arm, a tamoxifen for two years followed by letrozole for three years arm, and a letrozole for two years followed by tamoxifen for three years arm. Results indicated a statistically significant improvement in disease free survival at five years in the letrozole arms compared to the tamoxifen arms. There was no significant difference in overall survival, however.

**Sequencing with Tamoxifen**
Two European trials were designed to evaluate the potential benefit of switching to an AI after two years of tamoxifen. The ABCSG8/ARNO95 trial randomized women after two years of tamoxifen to receive either three years of anastrozole or three more years of tamoxifen. There was a statistically significant improvement in event-free survival and distant recurrence-free survival in the anastrozole arm compared to the tamoxifen arm.

Continued on page 4
I have thought about this column for sometime now, pondering what might be appropriate to discuss. One of the nurses I work with had a “cerebral bleed causing a stroke” and another nurse was recently diagnosed with renal cell cancer. Both have recovered remarkably and we are very grateful for this, however the fact remains that my colleagues have been critically ill and that is hitting too close to home. After reading Carole Bauer’s article about the passing of one of her colleagues, I decided that perhaps it is time to talk about taking care of ourselves.

As oncology nurses we teach our patients and their families about prevention, detection and treatment. We do smoking prevention programs for school children to decrease the risk of cancer in the next generation. We teach women about breast cancer awareness, run relays for the cure and participate in many other programs aimed at prevention and early detection and fundraising campaigns to further cancer research. Yet are we ourselves paying attention to all the warnings and vital “talk” we are giving to others?

The American Cancer Society estimates for 2006 are staggering. 1,399,790 new cases are predicted and 564,840 (22.7%) of those will die from their disease. Heart disease is America’s number one killer causing 28% of all deaths in the United States. Strokes are listed as number three. These figures are incredible. Each one of us knows someone personally, not just those we care for everyday.

If you have a family member who has been diagnosed with cancer, are you following the American Cancer Society Guidelines for screening?

As oncology nurses we teach our patients and their families about prevention, detection and treatment.

ACS GUIDELINES:

Breast Cancer
• Yearly mammograms starting at age 40
• Clinical breast exam (CBE) every 3 years for women in their 20s and 30s and every year for women 40 and over.
• Monthly breast self-exam (BSE) beginning at age 20
• Women at increased risk (for example, family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (for example, breast ultrasound or MRI), or having more frequent exams.

Colon and Rectal Cancer
Beginning at age 50, both men and women should follow 1 of these 5 testing schedules:
• yearly fecal occult blood test (FOBT)* or fecal immunochemical test (FIT)
• flexible sigmoidoscopy every 5 years
• yearly FOBT* or FIT, plus flexible sigmoidoscopy every 5 years**
• double-contrast barium enema every 5 years
• colonoscopy every 10 years

* For FOBT, the take-home multiple sample method should be used.
** The combination of yearly FOBT or FIT flexible sigmoidoscopy every 5 years is preferred over either of these options alone.

All positive tests should be followed up with colonoscopy.

Colorectal cancer screening earlier and/or undergoing screening may be indicated more often if there are any of the following colorectal cancer risk factors:
• a personal history of colorectal cancer or adenomatous polyps
• a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 first-degree relatives of any age)
• a personal history of chronic inflammatory bowel disease
• a family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer)

Heart disease is America’s number one killer causing 28% of all deaths in the United States.

Prostate Cancer
Both the prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) should be offered annually, beginning at age 50, to men who have at least a 10-year life expectancy. Men at high risk (African-American men and men with a strong family history of one or more first-degree relatives [father, brothers] diagnosed before age 65) should begin testing at age 45. Men at even higher risk, due to multiple first-degree relatives affected at an early age, could begin testing at age 40. Depending on the results of this initial test, no further testing might be needed until age 45.

Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so that they can make an informed decision about testing.

Thanks for listening! I am sending you all wishes happiness and health now and in the coming year.
Kathleen Blazoff:

My oncology nursing days began before graduation from the Medical College of Ohio (MCO) in 1983. There was a summer internship in oncology available prior to my senior year. I needed a full time job and I wanted to stay in the Toledo area. (I hail from Lorain, Ohio – and – yes, I am a Buckeye Fan!). Lucky me! My name was pulled out of a hat. I attended class one day a week and worked the other 32 hours on 4AB (Hematology/Oncology/ Gynecology Oncology) at MCO in Toledo. I had a great mentor, who remains my good friend. Lisa Hartkopf-Smith was instrumental in my decision to choose oncology as my specialty. I can’t stress enough the importance of mentoring.

Today in my palliative care position at St John Riverview in Detroit, 50% of my patients are oncology. The premise of palliative care is to assist the patient with comfort care and symptom management while continuing to actively treat a chronic disease. Of my current patient base, 30% are pain consults and 30% are end of life issues.

This is a new challenge in my life and career. As an advanced practice nurse I have had three roles: 1) NP in head and neck cancer, 2) NP –GYN/ONC and 3) Palliative care. Each role has been a building block on the other. Everyday there is something new to learn. Currently in the St John System we are working with Duke on a palliative care project. I am on the working group for development of a palliative screening tool. I also serve on St. John’s ethics committee, critical care committee and pain committee.

My two major career accomplishments thus far, have been: support group developments at Henry Ford and Oakwood. My head and neck patients at HFH and Gyn/Onc patients at Oakwood are the heroes that keep these groups going today!

In the past, Kathleen held the position of President at both the Toledo and Metro Detroit ONS chapters. She finds great pride in the fact that the year MDONS won the Chapter Excellence Award, she was president. Currently she is awaiting word on a poster submission from the Michigan Council of Nurse Practitioners and has her eye on pursuing a Ph.D., with a palliative research component.

She recently celebrated her 20th wedding anniversary with her husband and “Marathon” partner (They did it in under 2 hours!). Not only does she sing her husband’s praises but also those of her sons who are 14 and 16 year-old high school athletic stars.

Oh wait! There is one more star that she holds in highest regard, and that is Pat Abele, her role model and friend, who nominated her for 2006 MDONS AOCN of the Year.

Congratulations Kathy Blazoff.

Submitted By: Susan Wozniak RN, BS, OCN

Meeting Summaries

August

Treatment of Sarcomas

Presented by Shirish Gadgeel, M.D.
Summarized by Kay Reinke RN/OCN

Dr. Shirish Gadgeel brings to the MDONS podium an educated and informative presentation of soft tissue sarcoma (STS). Dr. Gadgeel’s lecture on this invasive disease offers the statistics, etiology, nomenclature, symptoms, staging, risks factors and the clinical approach of treatment modalities. This lecture also included specifics related to osteosarcoma and Gastro Intestinal Sarcoma (GIST).

Statistics of STS, as presented by Dr. Gadgeel, include the incidence of 10,000 new cases, which represent 1-2% of all adult cancers and 7-15% of childhood malignancies. The median age of occurrence of STS is 50-55 years old with a 5 year survival rate of 50%. This cancer occurs in the body’s connective tissue and is most commonly found in the upper and lower extremities. However STS can occur any where in the body where connective tissue is present. The invasive nature of STS affects the tissue that holds the body parts together and connects one body part to another.

The etiology of STS is variable. STS may be the result of treatment for other cancers. Ionizing radiation can be another causative factor. There is an average latency of ten years from the initial treatment with ionizing radiation of prior tumors such as lymphoma, breast and cervical cancers. Dr. Gadgeel also noted that if the etiology of STS is from prior radiation treatment, there is a poor prognosis. Additional etiologies include chemical exposures to phenoxyacetic acid, chlorophenols, thorotrast vinyl chloride and arsenic. Chronic lymphedema such as with Stewart–Treves syndrome and immune suppression as occurs with Kaposi sarcoma are additional causative factors for STS.

The system of naming STS is according to the tissue it resembles not the origin where it is found. Dr. Gadgeel pointed out that there are specific sub-type exceptions and suggests not getting lost in naming these exceptions. STS symptoms may be insidious and present as a painless mass, mild pain or difficulty in mobility of a specific body area. The site of a mass larger than eight to nine centimeters would be visualized on a CT scan. Diagnostics may include a chest x-ray or a CT scan of the lung, bone, abdomen and area surrounding the mass. An MRI of the primary lesion would be included for staging. Risk factors for distant or local recurrence is based upon prognostic factors and relative risk related to the grade of the tumor such as grade, location, size, and the notation of positive marginals.

Treatment modalities depend on prognostic factors and the nature of the tumor. Size, grade, site, depth and type of tumor (i.e.: rhabdomyosarcoma or Small Cell Lung Cancer). Therefore, larger tumors and those with distant metastasis would have treatment indications of not only chemotherapy, but also resection of the tumor. The main goal of tumor resection would be to achieve the most complete resection with the least amount of impact on the function. Surgery is the corner stone of treatment for this type of cancer. There is documentation of the impact from radiation treatment if it is added to the regimen of surgery and chemotherapy. Radiation treatment may be given before or after surgery, however pre-op radiation treatment increases the chance of wound healing complications and infection in the surgical wound. If the tumor margin is less than 1cm radiation treatment would be treatment consideration, however a positive margin can not be compensated by radiation therapy.

Tumor size depicts the type of treatment modality. A low-grade tumor, with a size less than 5cm may be treated with surgery alone. This may be sufficient to...
Hormone Therapy for Early Breast Cancer: Deal or No Deal

Continued from page 1

The ITA (Italian Tamoxifen-Arimidex) trial sequenced anastrozole after two to three years of tamoxifen therapy. At nearly three years of follow-up, the disease-free survival was longer in the anastrozole arm, and the locoregional recurrence was significantly lower than in the tamoxifen arm. This study was actually closed early due to the superiority of anastrozole over tamoxifen.

The IES (Intergroup Exemestane Study) trial randomized women who had completed two to three years of tamoxifen therapy to receive either exemestane or tamoxifen to complete five years of therapy. The exemestane arm was associated with a disease-free survival benefit but no significant overall survival benefit.

Extending Therapy after Five Years

The MA.17 trial compared five years of letrozole therapy versus placebo in women after completing five years of tamoxifen therapy. Studies have already determined that extending tamoxifen therapy beyond five years does not further improve patient outcomes. This trial demonstrated that letrozole compared with placebo significantly improved disease-free survival in all women, and improved overall survival in node-positive patients.

Side Effect Profile of Aromatase Inhibitors

All three AIs are associated with more musculoskeletal disorders, fractures, and osteoporosis, when compared to tamoxifen. The risk of serious side effects such as thromboembolic events, endometrial cancers, and vaginal bleeding is greater with tamoxifen. Hot flashes are more common with tamoxifen. Studies are ongoing to determine cardiac risks and the long-term consequences of AI therapy.

References:


2) NCCN Breast Cancer Clinical Practice Guidelines Update – Vol. 3 suppl.1, 2005; S7-11.


Meeting Summaries

August

Continued from previous page

cisplatin, ifosfamide and methotrexate (MTX) as well as surgery with wide margins including limb salvage in 85% of patients. The current survival statistic of patients treated with chemotherapy, surgical resection followed by radiation therapy is 60-65%.

The final lecture topic was GIST. The statistics document 2000 to 5000 new cases in the United States with a higher incidence predicted as further tissue types are discovered. The clinical presentation of GIST is often asymptomatic especially if the lesion is small. Signs and symptoms are related to location and size of tumor and include:

- Vague gastro-intestinal pain or discomfort
- Anemia
- Anorexia
- Weight loss, nausea, fatigue
- Acute intra-peritoneal bleeding or perforation

GIST may occur anywhere along the gastro-intestinal tract or elsewhere in the abdomen or peritoneum. There is a higher incidence if GIST in the 40-60 year age group with a slightly higher incidence in men. This sarcoma has recently been identified as a distinct clinical and histo-pathological entity and was previously misclassified as Leomysarcoma or other spindle cell cancers. Diagnostic work up includes abdominal CT scan, PET scan and biopsy. Treatment modality guidelines include surgery in conjunction with the chemotherapy agents such as imatinib (Gleevec®) initially or ifosfamide and imatinib.

In summary this presentation by Dr. Gadgeel indicates the necessity for clinicians to remain updated in cancer topics and to continue collaboration with each other to offer the highest level of state-of-the-art treatment modalities. We are on the horizon of great advances in the treatment of cancer patients. Lectures such as presented here are imperative to accent the care we can offer our patients.
The screening of older adults is generally inadequate and leads to a diagnosis in later stages. The surgical staging is also inadequate. Patients over 71 years old are less likely to have sufficient lymph node evaluation than younger patients. This can lead to a series of challenges related to caring for the older adult diagnosed with colorectal cancer.

The challenges associated with the older adult diagnosed with cancer include comorbid conditions, treatment issues, family concerns, self-care concerns and delayed diagnosis. Many of older patients present to their physician with another serious health condition in addition to the cancer. This often disqualifies individuals from participating in clinical trials. Therefore, the samples used in trials are not adequately representative of the elderly population.

Patients with comorbidities often require several medications. This can cause difficulties with medication administration for their cancer. For example, older adults receiving chemotherapy may not be able to take certain antiemetics due to a possible interaction with other medications.

Although there is no specific tool that is consistently used, it is recommended that a geriatric assessment tool be used to appropriately assess each older adult who presents for treatment. This tool should include: functional status, nutrition, comorbidities, mental status, emotional condition, socioeconomic resources and family support. Quality of life should also be addressed. It is important to know how each individual patient defines quality of life and care should be taken to attempt to fulfill the wishes of the patient.

Nurses play an important role in treating older adults diagnosed with colorectal cancer. When these patients are hospitalized it is critical that the nurse is aware of the comorbid conditions and frequently assesses for drug interactions or toxicity. The nurse can also teach lifestyle changes, such as: reduction of alcohol consumption, stress reduction, dietary changes and increased physical activity. Nurses can also interact with family members and offer support when indicated. Referrals to social workers or community support groups may be very helpful to an overwhelmed caregiver. Mr. Jones concluded his informative presentation with these observations: screening and prevention are critical at any age, treatment challenges necessitate thorough assessment and individualized care and clinical trials addressing cancer treatments in older adults are essential.
From the President  Lisa M. Zajac, MSN, APRN-BC, OCN

According to the Webster’s Dictionary, success is defined as “a favorable course or a termination of anything attempted”. Often, in the field of oncology, we define success in terms of remission. Other times, success is defined as a peaceful journey into eternity for our patients. When Webster’s definition is divided into two definitions, “a favorable course” and “a termination of anything attempted”, patient situations come to mind.

Take for instance, the story of Blake. In 2001, when he was a year old, Blake was diagnosed with Stage IV peripheral neuroectodermal tumor (PNET). He underwent a course of chemotherapy, and then received an autologous stem cell transplant at the age of 18 months old. Blake remains in remission. At this time, when not attending kindergarten, you can find him skating with his teammates on the Cobra’s hockey team. Because of the treatment and care that he received, Blake’s story defines what Webster’s states as a “favorable course”.

On the flipside of Blake’s story, we have the other half of the definition of success, “a termination of anything attempted”. Too often in oncology, we experience this half of success. Even at the termination of an attempt to cure cancer, we still have the ability to touch the lives of our patients. I know that we all have many stories of times that oncology nurses made someone’s journey into eternity peaceful. We need to know that we have achieved as much success in these patient situations as well as those who had “a favorable course”.

In conclusion, we, as oncology nurses, are successful during every patient encounter. Whether we serve as a coach for our patients as they prepare for eternal life, or remain in the stands of an ice arena while cheering on our sports stars, we have achieved success!

I hope that all of you strive to be the “Most Valuable Player” on your oncology care team!

Success is never final.
Winston Churchill

Meeting Summaries >>>>>>>>>>>>>>>>>>>>>>>>>>>

October  Continued from previous page

The second chakra is the Sacral Chakra. It resonates to the color orange. It nourishes the lower abdominal and sacral spinal regions. It helps us understand what it means to be male or female.

The Solar Plexus is the third chakra. Its color is yellow, and it controls the digestive tract and the lumbar spine area. This also includes our intuition or “gut feelings”.

The fourth chakra is the Heart Chakra. The color is green, and it nourishes the heart, lungs, and organs of the chest cavity. It allows us to love and be loved.

The Throat Chakra is the fifth chakra. It resonates to the color blue, and involves the throat area and associated structures. It helps us speak our truth.

The sixth chakra is called the Eye Chakra. It affects the central nervous system, brain stem, vision and hearing. Its color is indigo. This chakra allows for clear thinking.

The Crown Chakra is the seventh chakra. It resonates to the color purple, and is our connection to the universe. It allows unconditional love and peace to be a part of us.

After this thorough explanation, we were able to observe Ms. Grohman performing an energy healing session on a volunteer. This included an explanation of auras and what they can tell us of a person’s physical, emotional, or spiritual troubles. This information can help a practitioner focus the energy healing session.

At the conclusion of the evening, we attempted to conduct a short healing session on a partner, putting to use the information we had received during the lecture.

Program Schedule >>>>>>>>>>>>>>>>>>>>>>>>>>>

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Event Details</th>
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</thead>
<tbody>
<tr>
<td>January 9</td>
<td>Tuesday</td>
<td>Dr. Mario Lacouture will be speaking on the management of chemotherapy induced rash. This will be a restaurant meeting, and will probably require an RSVP. Watch your mail box.</td>
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<tr>
<td>February 14</td>
<td>Wednesday</td>
<td>MDONS annual conference</td>
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<tr>
<td>March 13</td>
<td>Tuesday</td>
<td>Dinner meeting at Larco’s in Troy. There will be an RSVP, and space is limited. Topic will be Genentech drugs.</td>
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<tr>
<td>April 11</td>
<td>Wednesday</td>
<td>Chiropractic for Oncology patients, at Providence Hospital</td>
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<tr>
<td>May 8</td>
<td>Tuesday</td>
<td>President’s Dinner at Gilda’s Club in Royal Oak</td>
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<tr>
<td>June 14</td>
<td>Wednesday</td>
<td>Bone Health for Oncology patients at St. John, Macomb</td>
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ONS Member-Bring-A-Member

MDONS brings the “ONS Member-Bring-A-Member” campaign to the Metro Detroit chapter. Participating is easy. Just tell your colleagues about the many benefits of MDONS membership and invite them to join the chapter. You only need to recruit one member to earn one entry into our membership recruitment virtual “hat”. The more members you recruit, the more entries you earn! In addition, if you recruit a new member, your efforts will be recognized in our quarterly newsletter. Each time a new member joins MDONS using an application with your name listed as the referring member, MDONS put your name in the hat. Starting in 2007, each December a winner will be chosen, and the prize will be, your choice: a three year membership to MDONS or paid conference attendance for the annual MDONS conference, held annually in February. Applications are available at monthly meetings - or online at: http://www.metrodetroitons.org/

Register Now for Premier Cancer Nursing Research Conference

The ONS 9th National Conference on Cancer Nursing Research will be held February 8-10, 2007, in Hollywood, CA. Make your plans now to come to this exciting event. It’s the only conference dedicated specifically to oncology nursing research.

New Online Course on Lung Cancer Starts November 16

Register now for the new Site-Specific Cancer Series: Lung Cancer Online Course. This course provides detailed information to help nurses understand the current management of lung cancer. Earn 14.2 contact hours of CNE upon successful completion of this faculty-led course.

MDONS acknowledges...

MDONS acknowledges three poster presentations for 9th National Conference on Cancer Nursing Research.

Dorothy Haddrill will present her research in a poster presentation entitled: Adult chemotherapy infusion patients have a high level of satisfaction with ambulatory treatment.

Rita J. Dibiase will present her research in a poster presentation entitled: Chemotherapy education: Effects on knowledge and uncertainty in cancer patients.

Carole Bauer will present her research in progress as a poster presentation entitled: Testing the efficacy of two products for the prevention of perineal dermatitis in immune compromised patients: A randomized clinical trial.

Learn How the CNS Role Has Evolved Since the 1950s

Read the November ONS News to learn how oncology CNSs have become change agents, consultants, proponents of quality care, and supporters of evidence-based practice. Are you in favor of the National Council of State Boards of Nursing draft vision paper on advanced practice nursing? Take the ONS News Instant Poll to respond.

Get information on Nonpharmacologic Management of VCF

ONS now offers two new ways to gain valuable information on the care of patients with cancer. Earn free CNE through the new, interactive webcast, Non-Pharmacologic Approaches to the Management of Vertebral Compression Fractures. Also check out the new newsletter, Vertebral Compression Fractures in Oncology: Clinical Review & Case Studies.

Earn a Free Registration to the 2007 Congress in Las Vegas

Earn a Free Registration to the 2007 Congress in Las Vegas. You can earn great rewards through the ONS Member-Bring-a-Member program. Start referring your colleagues to ONS and you could be on your way to Las Vegas next spring!

Did You Know?

As an ONS member, you are entitled to one free special interest group (SIG) membership annually. If you aren’t a SIG member, now is the time to take advantage of this opportunity to network with colleagues that share similar interests. Start getting more out of your ONS membership today!
The Chapter Capsule

...is a publication of the Metropolitan Detroit Chapter of the Oncology Nursing Society. MDONS is devoted to improving the quality of care given to patients experiencing cancer.

This newsletter is published four times a year, in spring, summer, fall and winter. Letters and articles from members are welcomed. All material is subject to editing for space and clarification. Neither the Metro Detroit Chapter nor the ONS National Office assumes responsibility for opinions expressed herein. Acceptance of manuscripts does not indicate or imply endorsement. Materials may be submitted to:

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