Colorado Society of Clinical Pathologists

APPLICATION FOR MEMBERSHIP

DATE_____

1. MEMBER CATEGORY (Check one).

Active: _____ Resident: _____ Retired: _____

2. NAME: _____
(Last) (First) (Middle)

3. OFFICE ADDRESS: _____
Street City State Zip

4. OFFICE PHONE: _____ FAX: _____ CELL: _____

5 HOME ADDRESS: _____
Street City State Zip

6. HOME PHONE: _____ E-MAIL: _____

7. MEDICAL EDUCATION: School: _____From_____ To_____

8. INTERNSHIP: _____From_____ To_____

9. RESIDENCY: Hospital: _____From_____ To_____

Hospital: _____From_____ To_____

10. FELLOWSHIP TRAINING OR SPECIALTY TRAINING IN PATHOLOGY

Hospital: _____ From_____ To_____

Hospital: _____ From_____ To_____

11. TEACHING AND/OR HOSPITAL APPOINTMENTS:

Title_____ Hospital or Medical School _____ From_____ To_____

Title_____ Hospital or Medical School _____ From_____ To_____

Title_____ Hospital or Medical School _____ From_____ To_____

Title_____ Hospital or Medical School _____ From_____ To_____

12. Licensed to practice in the following states (give dates)

_____

13. Are you a member of your state medical society? Yes_____ No___

Name of Society _____

14. MEDICAL SOCIETY MEMBERSHIPS: AMA: Yes ___No___ CAP: Yes___ No___

ASCP: Yes___ No ___ ASC: Yes_____ No_____

15. OTHER MEDICALSOCIETIES:

_____

16. OFFICES (past and present) held in medical societies:

_____

I hereby pledge myself to the highest ethical standard in the practice of Pathology, and, if elected to membership in the Colorado Society of Clinical Pathologists, shall conduct myself in conformity with the Principles of Medical Ethics of the American Medical Association.

APPLICANT'S
SIGNATURE_____

Date

Names and contact information of two Pathologists from whom information regarding the applicant may be obtained:

1. Dr._____

   Address and Phone_____

2. Dr._____

   Address and Phone_____

Return completed application to:

Colorado Society of Clinical Pathologists
PO Box 366
Franktown, CO 80116