

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 MEDICAL SOCIETIES:

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

5523 Yank Way

Arvada, CO 80002