ASCCP

The society for lower genital tract disorders since 1964

Membership Application

Name: _____

Company/Institution: _____

Address: _____

City: _____ **State/Providence:** _____ **Country:** _____

Postal Code: _____ **Email:** _____ **Phone:** _____

Membership Type:

☐ Physician Member	$175	☐ World Bank Rate*	$125
☐ Nurse/Nurse Practitioner/Midwife	$150	☐ Resident*	$35
☐ Physician Assistant	$150	☐ Resident with Journal Subscription*	$85
☐ Researcher	$150	☐ Student*	$35
☐ Emeritus*	$0	☐ Student with Journal Subscription*	$85
☐ Emeritus with Journal Subscription *	$50	***See website for specific requirements**	

TOTAL $_____

Credentials (select all that apply):

☐ ANP	☐ ARNP	☐ DNP	☐ MBChB	☐ MSN	☐ PANCE	☐ Other (List Below)
☐ AOCN	☐ BSN	☐ DO	☐ MD	☐ NP	☐ RN	
☐ AOCNP	☐ CNA	☐ FNP	☐ MPH	☐ PA-C	☐ PhD	_____
☐ ARC-PA	☐ CNM	☐ LPN	☐ MSc	☐ PhramaD	☐ WHNP	_____

Specialty (select all that apply):

☐ Dermatology	☐ Internal Medicine	☐ Pediatrics
☐ Family Medicine/ General Practice	☐ Internist	☐ Pharmacy
	☐ Ob/ Gyn	☐ Surgery
☐ Gyn Oncology	☐ Oncology	☐ Other_____
☐ Ob/ Gyn	☐ Pathology	

Professional Setting (select all that apply):

☐ Academia (teaching/research)	☐ Hospital	☐ Office/Clinic
☐ Government	☐ Industry	☐ Other_____

Payment Information:

Method: ☐ Check (Checks may be mailed to the ASCCP Office at the address below.)

Credit Card: ☐ Visa ☐ American Express ☐ Discover ☐ MasterCard

Credit Card Number: _____

Expiration Date _____/_____ Security Code: _____
(Month) (Year)

Name on Card: _____

Signature: _____

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