



Improving Lives Through the Prevention & Treatment
of Anogenital & HPV-Related Diseases

Trainee Group Membership Application

Institution/Company: _____

Residency Director Name: _____

Address: _____

City: _____ State/Province: _____ Country: _____

Postal Code: _____ Phone: _____

Email: _____

Please indicate total number of the Trainees you are paying for in the box below. Each individual will need to complete the Trainee Membership Application, which should be attached with this form.

Qty	Membership Type		Price Per Membership	Subtotal
	Trainee Membership	x	\$15	
	Trainee with Online Journal Subscription	x	\$65	
	Trainee with Online & Print Subscription	x	\$100	
TOTAL				

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: _____

Return the Group Trainee Membership Application and Trainee Application(s) via email, fax, or mail.

1530 Tilco Dr, Suite C, Frederick, MD 21704 | P: (301) 8557-7877 | F: (301) 433-7971 | info@asccp.org



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Trainee Membership Application

Name: _____

Institution/Company: _____

Residency Director Name: _____

Address: _____

City: _____ State/Province: _____ Country: _____

Postal Code: _____ Phone: _____

Email: _____

Category(select one):

☐ Student ☐ Resident ☐ Fellow ☐ Postdoc

Credentials (select all that apply):

<input type="checkbox"/> ANP	<input type="checkbox"/> ARNP	<input type="checkbox"/> DNP	<input type="checkbox"/> MBChB	<input type="checkbox"/> MSN	<input type="checkbox"/> PANCE	<input type="checkbox"/> Other (List Below)
<input type="checkbox"/> AOCN	<input type="checkbox"/> BSN	<input type="checkbox"/> DO	<input type="checkbox"/> MD	<input type="checkbox"/> NP	<input type="checkbox"/> RN	_____
<input type="checkbox"/> AOCNP	<input type="checkbox"/> CNA	<input type="checkbox"/> FNP	<input type="checkbox"/> MPH	<input type="checkbox"/> PA-C	<input type="checkbox"/> PhD	_____
<input type="checkbox"/> ARC-PA	<input type="checkbox"/> CNM	<input type="checkbox"/> LPN	<input type="checkbox"/> MSc	<input type="checkbox"/> PharmaD	<input type="checkbox"/> WHNP	_____

Specialty (select all that apply):

<input type="checkbox"/> Dermatology	<input type="checkbox"/> Internist	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Ob/Gyn	<input type="checkbox"/> Surgery
<input type="checkbox"/> General Practice	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gyn Oncology	<input type="checkbox"/> Pathology	
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Pediatrics	

Professional Setting (select all that apply):

<input type="checkbox"/> Academia (teaching/research)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Office/Clinic
<input type="checkbox"/> Government	<input type="checkbox"/> Industry	<input type="checkbox"/> Other _____

In order to comply with the General Data Protection Regulation (GDPR), members must provide consent for their data to be transferred to third party vendors. If you wish to opt out of the member benefits below, please check the boxes.

- ☐ Opt out of data being sent to Multiview for your subscription to the ASCCP Advisor (e-weekly newsletter)
- ☐ Opt out of data being sent to ASCCP's publisher for your Journal Subscription (only applicable to those who subscribe)



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Trainee Membership Application (continued)

Licensure:

Has your license to practice ever been revoked? ☐ Yes ☐ No

Have you ever been denied a license to practice? ☐ Yes ☐ No

Have you ever voluntarily surrendered your license? ☐ Yes ☐ No

Have you ever been the subject of any professional misconduct proceedings or are they pending? ☐ Yes ☐ No

Have any sanctions or restrictions been imposed by any licensing authority? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

Have you ever been convicted of committing an act constituting a crime or felony? ☐ Yes ☐ No

Return the this form to your Residency Director/Department Chair