



ASCCP

The Society for Lower Genital Tract Disease

APPLICATION FOR MEMBERSHIP

NAME _____

	First	Middle	Last
UNIVERSITY or COLLEGE _____			DEGREE _____ YEAR GRADUATED _____
NURSING /ADVANCED CLINICAL SCHOOL _____			DEGREE _____ YEAR GRADUATED _____
MEDICAL SCHOOL _____			DEGREE _____ YEAR GRADUATED _____
RESIDENCY TRAINING (Specialty and institution) _____			DATE _____
RESIDENTS (Current program year, e.g., PGY2) _____		Expected Date of Graduation _____	
FELLOWSHIP (if applicable) _____			DATE _____
CERTIFICATION (if applicable) _____			DATE _____

Please complete the following sections carefully to assist the membership committee in reviewing your application. If your colposcopy training was completed exclusively during residency or fellowship, your program director **MUST** support your application with an outline of your colposcopy curriculum. Those who have not undergone colposcopy or pathology training must document their professional involvement through pathology/cytology, nursing, public health and/or research/basic science (e.g., administrative nurse for colposcopy clinic, CDC employee, etc).

COLPOSCOPY OR CERVICAL PATHOLOGY TRAINING:

COLPOSCOPY COURSE:	BASIC (date) _____	INSTITUTION _____
		ACCME-Accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ADVANCED (date) _____	INSTITUTION _____
		ACCME-Accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ASCCP BIENNIAL MEETING (date) _____	INSTITUTION _____
		ACCME-Accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No

LICENSURE: Has your license to practice ever been revoked?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 (NOTE: This excludes minor traffic violations)

The following is for informational purposes only and is not required for membership.

PRACTICE SPECIALTY (check all that apply) Family Practice Pathology Residency-Gynecology
 Gynecology Public Health Residency-Family Medicine
 Gyn Oncology Research/Basic Science Osteopathic Medicine
 Nursing VA Provider

PUBLICATION: _____

SOCIETY MEMBERSHIPS: _____

Submit your application with the dues to join the ASCCP. Your membership period runs a calendar year from the date approved.
Active Membership Dues: \$200.00 (includes the \$25.00 initiation fee and \$175.00 dues)
Resident Dues: \$35.00 (for duration of residency)

I hereby apply for ACTIVE RESIDENT membership in the American Society for Colposcopy and Cervical Pathology.
I agree to be bound by the bylaws of the organization that may be found at www.asccp.org/about-asccp/bylaws.

APPLICANT SIGNATURE: _____ DATE: _____

Would you like your address included in the ASCCP online membership directory? Please mark your mailing preference, only one address will be used in the directory.

ASCCP mailings ASCCP online directory

RESIDENTIAL ADDRESS: _____

City State Zip Code

ASCCP mailings ASCCP online directory

PROFESSIONAL ADDRESS: _____

City State Zip Code

TELEPHONE: _____ FAX: _____ EMAIL: _____

Do you wish to receive email, including our monthly newsletter from the ASCCP Yes No

Mail or fax completed form to: ASCCP National Office
152 W Washington St
Hagerstown, MD 21740
Phone: (301) 733-3640
Fax: (301) 733-5775
www.asccp.org

PAYMENT INFORMATION (PLEASE COMPLETE)

Amount enclosed/to be charged \$ _____

Payment made by check (payable to ASCCP) or by credit card: Visa MasterCard American Express

Card Account Number: _____ Expiration Date: _____ CVV3 _____

Name on Card: _____ Signature X _____

Address if different from address shown above: _____

