ASCCP

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

Institutional Membership Application

Institution/Company:_____

Program Representative Contact Name:_____

Address: _____

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

Postal Code:_____ **Phone:** _____

Representative's Email:_____

Please indicate total number of the Members you are paying for in the box below. Each individual will need to complete the Membership Application, which should be attached with this form. NOTE: Trainee Membership is excluded. You must have a minimum of five members to receive the discount.

Qty	Membership Type		Price Per Membership	Subtotal
	Physician Membership	x	$225	
	Physician Assistant, Researcher, Nurse/Nurse Practitioner/Midwife Membership	x	$175	
			SUB-TOTAL	
			MINUS 10% DISCOUNT	
			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: _____ Zip/Postal Code:_____
(Month) (Year)

Name on Card: _____

Signature:_____

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

ASCCP, c/o SHS Services 131 Rollins Ave, Suite 2, Rockville, MD 20852 | P: (301) 363-0477 | F: (301) 433-7971 | info@asccp.org

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

Membership Application

Name:_____

Address (if different from institution/company address)_____

_____

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

Postal Code:_____ **Phone:** _____

Email: _____

Category(select one):

☐ Physician ☐ Physician Assistant ☐ Nurse/Nurse Practitioner/Midwife ☐Researcher

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	☐ PharmaD	☐ WHNP	_____

Specialty (select all that apply):

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

Professional Setting (select all that apply):

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

Gender

☐ Female ☐ Male ☐ Non-Binary ☐ Prefer Not to Indicate

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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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