



# AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY

## APPLICATION FOR MEMBERSHIP

Please print or type:

NAME: \_\_\_\_\_  
First Middle Last Degree

MEDICAL SCHOOL: \_\_\_\_\_ YEAR GRADUATED: \_\_\_\_\_

NURSING SCHOOL: \_\_\_\_\_ DATE: \_\_\_\_\_

RESIDENCY TRAINING:\* \_\_\_\_\_ DATE: \_\_\_\_\_

If now a resident, provide current program year with expected date of graduation: \_\_\_\_\_ DATE: \_\_\_\_\_

FELLOWSHIP/SPECIALTY TRAINING (if applicable): \_\_\_\_\_ DATE: \_\_\_\_\_

CERTIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_

### COLPOSCOPY OR PATHOLOGY TRAINING

Please complete the following sections carefully to assist the membership committee in reviewing your application.

COLPOSCOPY COURSE: BASIC (date): \_\_\_\_\_ INSTITUTION: \_\_\_\_\_  
ACCME-Accredited?  Yes  No

ADVANCED (date): \_\_\_\_\_ INSTITUTION: \_\_\_\_\_  
ACCME-Accredited?  Yes  No

COLPOSCOPY TRAINING IN RESIDENCY/FELLOWSHIP\* DATE: \_\_\_\_\_ INSTITUTION: \_\_\_\_\_

\*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. Please submit residency training documentation concurrently with this application.

- LICENSURE: Has your license to practice ever been revoked?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 so, please explain: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF COMMITTING AN ACT CONSTITUTING A CRIME OR FELONY?

Yes  No (NOTE: This excludes minor traffic violations)

HOSPITAL STAFF APPOINTMENTS: Have your medical or nursing staff appointments or clinical privileges been revoked, suspended, refused, reduced or not renewed in any health care facility? .....  Yes  No

THE FOLLOWING IS FOR INFORMATIONAL PURPOSES ONLY AND IS NOT REQUIRED FOR MEMBERSHIP.

PRIMARY HOSPITAL STAFF APPOINTMENT: \_\_\_\_\_  
Hospital Name

\_\_\_\_\_  
Address

MEDICAL SCHOOL FACULTY APPOINTMENT: \_\_\_\_\_  
School Name

\_\_\_\_\_  
Faculty Appointment \_\_\_\_\_

PUBLICATIONS: \_\_\_\_\_

SOCIETY MEMBERSHIPS: \_\_\_\_\_

**Membership Dues:** One time Initiation fee: \$25.00 payable at time of application for all categories of membership.

**Annual Dues:** \$140.00 October 1 - September 30 (*includes subscription to Journal of Lower Genital Tract Disease*)

**Optional Fee:** \$25.00 subscription to the quarterly Home Study Course, a self-assessment CME program on CD ROM

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.

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*RESIDENTIAL ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

PROFESSIONAL ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

\*If you are an international applicant, please provide your complete mailing address, including your postal code.

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