Colorado Society of Clinical Pathologists

APPLICATION FOR MEMBERSHIP

DATE____________________

1. MEMBER CATEGORY (Check one).

    Active: ______ Resident: ________ Retired: _________

2. NAME: ____
    (Last) (First) (Middle)

3. OFFICE ADDRESS: ____
    Street City State Zip

4. OFFICE PHONE: __________________ FAX: ____________________ CELL: ___________________

5 HOME ADDRESS: ____
    Street City State Zip

6. HOME PHONE: ____________________ E-MAIL: ___________________________

7. MEDICAL EDUCATION: School: ___________________________________From________ To_________

8. INTERNSHIP: ____From________ To_________

9. RESIDENCY: Hospital: ______________________________________From_________ To_____________

    Hospital: ______________________________________From_________ To_____________

10. FELLOWSHIP TRAINING OR SPECIALTY TRAINING IN PATHOLOGY

    Hospital: ______________________________________ From_________ To_____________

    Hospital: ______________________________________ From_________ To_____________

11. TEACHING AND/OR HOSPITAL APPOINTMENTS:

Title____________ Hospital or Medical School ____________________________ From________ To_____

Title____________ Hospital or Medical School ____________________________ From________ To_____

Title____________ Hospital or Medical School ____________________________ From________ To_____

Title____________ Hospital or Medical School ____________________________ From________ To_____

12. Licensed to practice in the following states (give dates)

____

13. Are you a member of your state medical society? Yes_____ No___

Name of Society ____

14. MEDICAL SOCIETY MEMBERSHIPS: AMA: Yes ___No___ CAP: Yes___ No___

ASCP: Yes___ No ___ ASC: Yes_____ No______

15. OTHER MEDICALSOCIETIES:

____

16. OFFICES (past and present) held in medical societies:

____

I hereby pledge myself to the highest ethical standard in the practice of Pathology, and, if elected to membership in the Colorado Society of Clinical Pathologists, shall conduct myself in conformity with the Principles of Medical Ethics of the American Medical Association.

APPLICANT'S
SIGNATURE____

Date

Names and contact information of two Pathologists from whom information regarding the applicant may be obtained:

1. Dr.____

   Address and Phone____

2. Dr.____

   Address and Phone____

Return completed application to:
Colorado Society of Clinical Pathologists
2760 E Flora Pl
Denver, CO 80210