

PACIFIC NORTHWEST SOCIETY OF PATHOLOGISTS

2033 Sixth Avenue, Suite 1100 Seattle, WA 98121

APPLICATION FOR MEMBERSHIP

Date of Application: _____

Name: _____

(First)

(Middle)

(Last)

Preferred/Mailing Address: _____

(Street)

(City/State)

(Zip)

Phone Number: _____ Fax Number: _____

Preferred/E-MailAddress: _____

Work Address: _____

(Street)

(City/State)

(Zip)

Work Number: _____ Fax Number: _____

Present Position: _____

PLEASE CHECK BELOW THE MEMBERSHIP STATUS YOU ARE SEEKING:

Active Physician/physicist in full time practice of pathology & certified by the American Board of Pathology or Royal College of Physicians & Surgeons of Canada.
\$300/3 years

Associate Physician/pathology assistant/other in full time practice of pathology & not certified.
\$300/3 years

Resident- Person occupying a residency or fellowship program in Pathology, or one of its recognized subspecialties
\$75-3years
(includes all meetings)

Pathology Trainee Individual in good standing in a pathology assistant training program
\$150/3 years

General Medical Education, Residencies, and Internships: (list schools and hospitals, years which attended or served, degrees received)
School/Hospital Years/ Degree

Details of Special training and experience in Pathology:

List medical societies (local, state, or provincial, national) of which you are a member:

Are you certified by the American Board of Pathology? _____ Year: _____ Specialty: _____

Are you certified by the Royal College of Physicians & Surgeons of Canada? Year: _____ Specialty: _____

Do you Limit your practice to Pathology: Yes _____ No _____ Clinical pathology: Yes _____ No _____

Other: _____

Signature: _____

Attach a copy of your current Curriculum Vitae

NOTE: Completed application forms must be accompanied by a check or money order for the checked amount above (US funds). This serves as entrance fee and dues for the current year in which applicant is voted in as a member.

<input type="checkbox"/> Enclosed is my check for payment	<input type="checkbox"/> Please charge my Visa or MasterCard
Name on card: _____	
Billing Address and Zip code _____	
Credit Card # : _____	Exp. Date: _____
Please return completed application along with payment to:	
PNWSP	Fax: (206) 441-5863
2033 Sixth Avenue, Suite 1100	Email: ddw@wsma.org
Seattle, WA 98121	Questions? (206) 956-3642

PLEASE RETURN TO: PNSP

2033 Sixth Avenue, Suite 1100
Seattle, WA 98121
Phone: (206) 441-9762
Fax: (206) 441-5863
Email: ddw@wsma.org

Reserved for Office Use:

Date Application Received: _____

Payment Received: _____