

# International Medical Student Membership Application Form

*(For individuals residing in a country other than the United States or Canada)*

**Eligibility**

You are eligible for International Medical Student membership if you are enrolled in a medical school accredited or approved by the appropriate regulatory body or Ministry for your country. Applicants in countries without an existing system of accreditation must have their membership approved by the ASCP Commission on Membership.

**Annual Dues** ..... **FREE**  
 (Membership includes access to labmedicine.com and ajcp.com)

**After you've completed this application...**

**Mail completed application to:**  
 ASCP Membership Services  
 33 West Monroe St., Suite 1600  
 Chicago, IL 60603-5617 USA; or

**FAX completed application to:**  
 ASCP Membership Services  
 1.312.541.4767

For questions about membership, please contact ASCP Membership Services at 1.312.541.4890, option 2 (USA & Canada), or 1.312.541.4890, option 2 (International), or Membership@ascp.org

**Contact Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date (MM/DD/YYYY): \_\_\_\_\_

(Please check preferred mailing address)

Home Address

Institution Address

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone (including country code): \_\_\_\_\_

Phone (including country code): \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

FAX (including country code): \_\_\_\_\_

FAX (including country code): \_\_\_\_\_

**Medical Education**

Institution \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Name of Pathology Dept. Chair \_\_\_\_\_ Graduation Date (MM/YYYY) \_\_\_\_\_

**Certification of Membership**

To the best of my knowledge, the information I have provided in this membership application is accurate. I agree to hold the American Society for Clinical Pathology, its members, officers and representatives free from any damage or complaint by reason of any action they may take in connection with this application.

**Applicant's Signature**

I hereby make application to become an ASCP International Medical Student Member.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**The mission of the American Society for Clinical Pathology is to provide excellence in education, certification, and advocacy on behalf of patients, pathologists, and laboratory professionals.**