

# Medical Student Membership Application Form

**Eligibility**

You are eligible for Medical Student membership if you are enrolled in a medical school accredited by the Liaison Committee on Medical Education or in an osteopathic medical school accredited by the American Osteopathic Association.

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

For questions about membership, please contact ASCP Membership Services at 800.267.2727, option 2 or Membership@ascp.org

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

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

**FAX completed application to:**  
ASCP Membership Services  
312.541.4767

**Contact Information**

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

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

**(Please check preferred mailing address)**

Home Address  Institution Address

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

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

FAX \_\_\_\_\_ FAX \_\_\_\_\_

**Medical Education**

Institution \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Pathology Dept. Chair \_\_\_\_\_ Graduation Date \_\_\_\_\_

**Verification**

This application must be signed by your program director, education coordinator, medical director or college advisor. Photocopies or stamped signatures are not accepted.

I hereby verify that the person listed on this application is currently enrolled in an accredited medical school.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**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 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.**