# CYTOLOGY ASSESSMENT

**By Fax:**
Fax to **317.569.0221**
and transmit a copy of
your purchase order.

**By Phone:**
**317.218.6502**
Monday–Friday (8am–5pm ET)
(Outside the US 312.541.4848)
Please have credit card
information ready.

**By Mail:**
ASCP
3462 Eagle Way
Chicago, IL 60678-1034
Include check payable to ASCP
or purchase order.

☑ **YES! Please renew my Cytology Assessment subscription for 2020 as indicated.**

| Cytopathology Assessment Program | Price/Program *Price Before 10/31* | Price/Program *Price After 10/31* | Quantity | # of Participants/Program | Program Price x Quantity |
|---|---|---|---|---|---|
| ☐ **NonGYN Assessment** (NGYN20-GLASS) | $775 | $899 | _____ | _____ | $ _____ |
| ☐ **NonGYN Digital** (NGYN20-DIGITAL) | $725 | $799 | _____ | _____ | $ _____ |
| ☐ **NonGYN Virtual** (NGYN20-VIRTUAL) | $699 | $699 | _____ | _____ | $ _____ |
| ☐ **GYN Assessment** (GYN20-GLASS) | $699 | $799 | _____ | _____ | $ _____ |
| ☐ **GYN Virtual** (GYN20-VIRTUAL) | $599 | $599 | _____ | _____ | $ _____ |

Total # of participants _____ x $90.00 per program = *Price Before 10/31* $ _____

Total # of participants _____ x $95.29 per program = *Price After10/31* $ _____

**For GYN, select prep type:**

☐ All SurePath

☐ All Thin Prep

**Assessment Program Subtotal:** $ _____

**Bundle Discount:** $ _____

**Grand Total:** $ _____

If both GYN and NonGYN programs are purchased, apply bundle discount (-$75)

**Participant Name**

**SHIP CUSTOMER #** **BILL CUSTOMER #**

**Please verify your shipping and billing information.** Indicate any changes.

**SHIPPING ADDRESS:**

**BILLING ADDRESS:**

Purchase Order Number (please attach a copy of the purchase order) _____

Contact Person _____

**E-mail (required)** _____

Phone _____ Fax _____

☐ I want to pay by credit card. Please call me at _____

Date/Time _____