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	Quantity	# of Participants/Program	Program Price x Quantity
☐ **NonGYN Assessment** (NGYN20-GLASS)	$899	________	____________________	$ ____________
☐ **NonGYN Digital** (NGYN20-DIGITAL)	$799	________	____________________	$ ____________
☐ **NonGYN Virtual** (NGYN20-VIRTUAL)	$699	________	____________________	$ ____________
☐ **GYN Assessment** (GYN20-GLASS)	$799	________	____________________	$ ____________
☐ **GYN Virtual** (GYN20-VIRTUAL)	$599	________	____________________	$ ____________

Total # of participants ______ x $95.29 per program = $ ____________

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 ____________________