ASCP **GYN 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.

Program	Price/Program	Quantity	# of Participants/Program	Program Price x Quantity
☐ **GYN Proficiency Testing 2020** (PT20-GLASS)	$1,099	_____	_____	$ ________________
☐ **GYN PT and Lab Comparison 2020** (PTLC20) *(GYN PT + one shipment of 12 high-quality glass slides with comparative results & statistics)*	$1,499	_____	_____	$ ________________

Participant Fee (PT-GLASS-PART)**:** Total # of Participants for PT _____ x $95.29 = (enter amount) **>** $ ________________

Subtotal: $ ________________

Recording Fee (PTCLIA20) for each additional CLIA GYN Certificate ________________ x $500 $ ________________

Grand Total $______________

Please mark your desired day to ensure your preferred testing.

2020: 1.☐☐ / ☐☐ 2.☐☐ / ☐☐

If choosing **PT & Lab Comparison***, please indicate in order of preference your date for the single shipment of Lab Comparison:

2020: 1.☐☐ / ☐☐ 2.☐☐ / ☐☐

Prep Type: ☐ **ThinPrep** ☐ **SurePath** ☐ **Conventional**

Please indicate the anticipated total number of screeners for the Prep Type Selected Above.

☐ **Primary Screeners** ☐ **Secondary Screeners**

Please select the OPTION you wish to use for your 2020 GYN PT test:

☐ **Online GYN PT Proctor Portal** *(same day results)*

☐ **Manual GYN PT process** *(results within 7 business days)*

*Lab Comparison is only one way to meet CAP LAP accreditation requirements, and offers up to 6.0 CME/CMLE credits. For a more in-depth education program, consider ASCP GYN Assessment. For more information, check the web at ascp.org.

CAP Accreditation #
(If using for CAP LAP purposes): ________________

CLIA #: ________________

Lab Director Name: ________________

Proctor #1 Name: ________________

Proctor Phone: ________________ Fax: ________________

Proctor Email: ________________

ASCP will follow-up for additional proctor and participant information.
ASCP Proctors are available for an additional fee.

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 ________________

Important!

For your protection, ASCP no longer gathers credit card info via mail or fax. Please call to give ASCP your credit card information.