P.O. Box 998, Sherwood, OR. 97140
Phone: (503) 625-2050 Fax: (503) 625-9285
E-mail: OPAofOR@aol.com

Oregon Pathologists Association

APPLICATION FOR MEMBERSHIP

NAME: _____ Date: _____
Last First MI

HOME MAILING ADDRESS: _____ HOME #: _____

CITY: _____ STATE:_____ ZIP:_____ EMAIL: _____

CURRENT LOCATION:_____ BUSINESS #:_____
Facility/Group Name

CELL #:_____

ADDRESS: _____ FAX #:_____

CITY: _____ STATE:_____ ZIP:_____ EMAIL:_____

Medical School:_____ Date of Graduation:_____

Residency Hospital:_____ Dates (from):_____ (to)_____

Address of Residency Hosp: _____

Licensed to Practice in: _____
State Date License #

_____
State Date License #

Diplomate American Board of Pathology: _____
Anatomic Pathology Date

_____
Clinical Pathology Date

Fellow College of American Pathologists: _____Date:_____

American Society of Clinical Pathologists: _____Date:_____

Type of Practice: Hospital_____ Private Laboratory _____ Academic_____
Government_____ Other (type) _____

Major Interest: General Pathology _____ Pathologic Anatomy _____
Clinical Pathology _____ Other _____

Applying for: [ ] Full/Active Membership: Pathologist [ ] Junior Membership: Fellow, Resident, Intern, Student

[ ] Associate Membership: Non-pathologist Physician, Clinician, Technician & Non-practicing Pathologist

Signature: _____ (Please specify M.D., D.O., Ph.D.)
D.M.D., D.D.S., D.V.M. Pathologist

This application MUST be accompanied by letters of sponsorship from 2 Full Members of the Oregon Pathologists Association, the ASCP or the CAP. You may submit one letter with two qualifying signatures.

Date Received: _____ Date Referred to Executive Committee/Membership: _____Action:_____