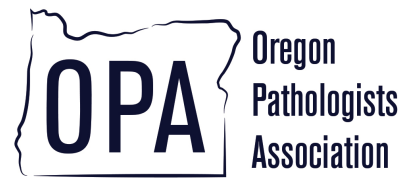


P.O. Box 998, Sherwood, OR. 97140
Phone: (503) 625-2050 Fax: (503) 625-9285
E-mail: OPAofOR@aol.com



APPLICATION FOR MEMBERSHIP

NAME: _____ Date: _____
Last First MI

HOME MAILING ADDRESS: _____ HOME #: _____

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

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

ADDRESS: _____ CELL #: _____
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

_____ Date
Clinical Pathology

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: _____