**The Pennsylvania Association of Pathologists**

APPLICATION FOR MEMBERSHIP

1. Instructions:

   a. Print or type all responses.

   b. Return completed form to: PAP, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820

   c. Application to be accompanied by first year's dues of $200 (if applying for active membership.) Make check payable to: Pennsylvania Association of Pathologists (residents and fellows are not required to pay annual dues.)

2. Application (X) for Active______ Resident______ Affiliate (nonphysicians)______

3. Name:____________________________________________ Date of Birth:__________________________
   (Last) (First) (M.I.)

4. Office Address: __________________________________________ Telephone: _______________________

   _______________________________________________________ Facsimile: _______________________

5. Home Address: _ ________________________________________ Telephone: _ ____________________

   _______________________________________________________ E-Mail Address: ___ ______________

6. Preferred Address (X) for Home_____ or Office_____

7. **Medical Education:**

   School ______________________________________________ Years:___________ to ____________

   School ______________________________________________ Years:___________ to ____________

   School/Medical Degree ___________________________________________________ Years:_________

8. **Post Graduate Appointments (Residency, Fellowship, Other):**

   _______________________________________________________ Years:___________ to ____________

   _______________________________________________________ Years:___________ to ____________

   _______________________________________________________ Years:___________ to ____________

   _______________________________________________________ Years:___________ to ____________

9. **Residents' projected date of completion** _______________________________________

10. **Other Experiences in Pathology or Medicine (military, government research, etc.):**

    ___________________________________________________________________________________________

    ___________________________________________________________________________________________

    ___________________________________________________________________________________________

**11. Hospital Appointments (including titles/rank):**

_______________________________________________________ Date:____________ to ____________

_______________________________________________________ Date:____________ to ____________

**12. Academic Appointments:**

Title _____________________ School ______________________ Date:____________ to ____________

Title _____________________ School ______________________ Date:____________ to ____________

**13. State Medical License (provide date of licensure and license number for each state):**

a. _____________________________ c. ________________________________

b. _____________________________ d. ________________________________

**14. Certification (American Board, Subspecialty Board,, etc.) and Dates:**

a. _____________________________ c. ________________________________

b. _____________________________ d. ________________________________

**15. Membership in Medical Organizations (AMA, CAP, ASCP, IAP, state and county medical societies, etc.):**

a. _____________________________ c. ________________________________

b. _____________________________ d. ________________________________

**16. State any occurrence of loss of hospital privileges, loss of medical license, or conviction of felony (if none, state "none").**

_____________________________________________________________________________________

_____________________________________________________________________________________

**17. List PAP member reference (minimum one):**

a. _____________________________ c. ________________________________

b. _____________________________ d. ________________________________

I hereby pledge myself to the highest ethical standard in the practice of medicine; I agree to abide by the rules and regulations of the Association and its Constitution and Bylaws and by such changes and amendments as may hereafter be properly adopted. I agree to revocation of the certificate of membership in this Association in the event that any of the statements made relevant to this application by me are false. I agree to hold Association, its members, officers, and agents free from any damage or complaint by reason of any action they or any of them may take in connection with this application:

________________________________________ ______________________

Signature of Applicant Date