



# AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.

## Membership Application

(PLEASE PRINT LEGIBLY)

**Name:** \_\_\_\_\_ **Title:**  DO  MD  Other  
**Contact Preference:**  Work  Home **Gender:**  Male  Female  
**Marital Status:**  Married  Single

### WORK

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

### HOME

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Please mark which address you would like in a AOCPP published directory.  Home  Work

Active Military?  Yes  No Rank \_\_\_\_\_ Until \_\_\_\_\_

Hospital or Clinic Affiliations: \_\_\_\_\_

Type of Practice (ex. AP, CP, etc.): \_\_\_\_\_ Fellowships: \_\_\_\_\_

AOA Member:  Yes  No AOA Member Number: \_\_\_\_\_ State Licensed: \_\_\_\_\_ License Date: \_\_\_\_\_ Number: \_\_\_\_\_

Premedical Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Medical Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Internship Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Residency Training: \_\_\_\_\_ Date(s): \_\_\_\_\_

ABP (MD) Certification  Yes  No Types (ex. AP, CP, etc.) \_\_\_\_\_ Date(s) \_\_\_\_\_

Board Certification (most recent renewal date): \_\_\_\_\_ Original Certification Date: \_\_\_\_\_ or  Not Taken

If accepted for membership I agree to abide by the Code of Ethics and the Constitution and Bylaws of AOCPP. By submission of this document, I authorize release of the information contained herein and in membership files of those organizations and hospitals to whom I may subsequently apply for membership; and the release to AOCPP by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

### MEMBERSHIP CATEGORY:

Active (\$300)  1st Year in Practice (\$150)  Retired (\$100)  Candidate (Resident) (\$10)

Were you referred by a AOCPP member?  Yes  No. If yes, please list \_\_\_\_\_

Amount \$ \_\_\_\_\_  Enclosed is my check

Please mail to the: American Osteopathic College of Pathologists, Inc.  
142 E. Ontario Street, Chicago, IL 60611  
Phone: 312-202-8197 • Fax: 312-202-8224