



MEMBERSHIP APPLICATION FORM

Name (Last, First, Middle)		Suffix (e.g. MD)	Date of Birth
Home Street Address			
Home City, State, Zip			
Home/Cell Phone		Personal Email address - Will only be used if work email is returned	
Company Name and Street Address			
Company City, State, Zip			
Work Phone		Work email	
Fax #	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Send communication to: <input type="checkbox"/> Work Email	*We never share email information <input type="checkbox"/> Personal Email

Colleges Attended	Degrees
Medical School(s)	Degrees
Residences in Pathology	Dates: From: To:
Present Hospital Appointments	Dates: From: To:
Other subspecialty training:	

Please check the membership category for which you are applying:

- ☐ **Active Member** - I am a certified pathologist currently practicing full-time.....\$150.00
☐ **Junior Member** - I am a physician currently enrolled in training programs leading to certification by the American Board of Pathology..... FREE
☐ **Retired Member** - I am a physician but have retired from practice.....FREE

PLEDGE OF MEMBERSHIP:

The Los Angeles Society of Pathologists, Inc. (LASOP) symbolizes the highest standards in the teaching of, research in, and practice of pathology. In accepting membership in the Los Angeles Society of Pathologists, Inc. I agree to foster and advance the principles and objectives and to abide by the decisions of the Board of Directors, and By-Laws of the Society, and the Principles of Ethics of the American Medical Association.

Also, I certify that the information given above is correct to the best of my knowledge.

SIGNATURE OF APPLICANT

DATE