Pennsylvania Association of Pathologists

Representation. Advocacy. Connection. Education.

Please type or print all responses

Type of Membership:

❒ Active	$200.00
❒ Resident	$20.00
❒ Affiliate (non-physicians)	$20.00

*Application to be accompanied by first year's dues (if applying for active membership).

Degree: ❒ MD ❒ DO

Name: _____ **Date of Birth:** _____

Office Address: _____ **Telephone:** _____

City, State, Zip _____ **Fax:** _____

Home Address: _____ **Telephone:** _____

City, State, Zip _____ **Preferred Address:** ❒ Home ❒ Office

Preferred Email: _____

Medical School: _____ **Year Graduated:** _____

Residents' projected date of completion: _____

_____ _____

Signature of Applicant Date

☐ Voluntary Contribution to the PAP Advocacy Fund (☐ $50 ☐ $75 ☐ $100 ☐ Other:_____)

Payment Options:

Total Payment: $_____

❒ Visa ❒ Master Card ❒ Discover ❒ Check made payable to "***Pennsylvania Association of Pathologists***"

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Name on Card: Card Number: Exp. Date CVV2 # (3-digit on back of card)

Card Billing Address: ❒ Home ❒ Business

Please mail completed form and curriculum vitae to:

Pennsylvania Association of Pathologists
777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

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