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 ☐ M ☐ F	Send communication to: ☐ Work Email ☐ Personal Email *We never share email information

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 Principals 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

Please email completed forms to LASOPmd@gmail.com or mail to:
Los Angeles Society of Pathologists, Inc.
Attn: Shirley Jacke * c/o Department of Pathology * Cedars-Sinai Medical Center * 8700 Beverly Blvd., Ste 8717
Los Angeles, CA 90048