

**WISCONSIN SOCIETY OF PATHOLOGISTS, INC.
APPLICATION FOR MEMBERSHIP**

CLASSIFICATION: _____ **ACTIVE (\$150)** _____ **RESIDENT (\$40)**

Your Name _____

Address _____

City _____ **State** _____ **Zip** _____

Office phone (_____) _____ **Office fax** (_____) _____

E-mail address _____

Date and Place of Birth _____

Pre-Medical Education

College _____ **Dates** _____

College _____ **Dates** _____

Academic Degrees and Years Obtained _____

Medical Education

School _____ **Dates** _____

School _____ **Dates** _____

Medical Degree _____ **School** _____ **Year** _____

Internship: Rotating

Hospital _____ **Years** _____

Special Training in Pathology (*Give date, institution, and pathologists under whose direction work was done*)

Hospital _____ **Years** _____

Name of Physician Director _____

Hospital _____ **Years** _____

Name of Physician Director _____

Hospital _____ **Years** _____

Name of Physician Director _____

Other experience in Pathology (*Military, Government, Research, etc*)

Give Particulars _____

Certification by the American Board of Pathology

Clinical Pathology _____ **Date** _____

Pathologic Anatomy _____ **Date** _____

Other _____

Are you certified in any other specialty board _____ **Yes** _____ **No**

Board _____ **Date** _____

Diploma from National Board of Medical Examiners

Date _____

Wisconsin License Number _____ **Date** _____

Licensed to practice in the following states (*Give dates*) _____

Medical Experience preceding practice of pathology _____

Hospital and Dispensary Staff Appointments (Past and Present) Dates/Titles

_____ **Dates** _____

_____ **Dates** _____

_____ **Dates** _____

Teaching Appointments (Past and Present)

Title _____ **School** _____ **Dates** _____

Title _____ **School** _____ **Dates** _____

Do you consider yourself to be a specialist in Pathology or one of its branches?

_____ **Yes** _____ **No**

Do you limit your practice to the field of Pathology? _____ **Yes** _____ **NO**

If not, what portion of your practice is pathology _____

In what other fields of medical or surgical practice are you engaged_____

State number of years during which practice has been limited to pathology

Location_____Dates_____

Location_____Dates_____

Location_____Dates_____

Medical Society Membership

_____Wisconsin Medical Society
_____American Medical Association

_____CAP
_____ASCP

Others_____

Offices held in these societies_____

Recommended by (application must be signed by two or more pathologists who know the applicant)

Signature_____Date_____

Name (Print Please)_____

Signature_____Date_____

Name (Print Please)_____

Signature_____Date_____

Name (Print Please)_____

Applicant's Signature_____Date_____

Return to: Wisconsin Society of Pathologists
563 Carter Court, Suite B
Kimberly WI 54136