

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

**CLASSIFICATION:** \_\_\_\_\_ **ACTIVE** \_\_\_\_\_ **RESIDENT**

**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 \_\_\_\_\_

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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 \_\_\_\_\_

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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: WSP  
P. O. Box 636  
Pewaukee, WI 53072