AMERICAN SOCIETY FOR CYTOTECHNOLOGY

Working Together. Shaping Our Future.

Membership Application

Membership Year is July 1 of current year – June 30 of following year.

Please print or type the following:

Full Name: _____ **Credentials:**_____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone Number: Home: _____   Work: _____

E-mail Address: _____
Please include your email address as the Voice is an electronic newsletter. *Visit* **www.asct.com** *anytime for current and past issues of the Voice. Email addresses will not be sold by ASCT.*

☐ *I do not wish to have my name, city, and state included on ASCT New Members list in the newsletter.*

How did you hear about the American Society for Cytotechnology and what prompted your interest to join?
_____

Please indicate any regional cytology groups of which you are a member: _____

I was referred by the following ASCT member: _____

Please check the type of membership for which you are applying. (*International members are accepted in all categories*).

☐ **General Membership**: open to Cytotechnologists, Pathologists, Physicians, Dentists, Veterinarians, PhDs and International members. General membership dues are **$60 per year**.

☐ **Student Membership**: open to students enrolled in approved schools of cytotechnology. A letter from the school (including completion date) is required. Student membership is **complimentary**.

☐ **Student Membership (first year out of school)**: upon graduation, current student members receive half price membership **$30 per year (one year membership)**.

☐ **Associate Membership**: open to all other individuals both national and international interested in diagnostic cytology who do not qualify for the other membership categories. Associate membership dues are **$60 per year**.

☐ **Retired Membership**: open to those who have worked in the field 10+ years, have officially retired from the profession and no longer work in cytology or related fields (sales rep, etc.) **Dues are $30 per year.**
Date of retirement: _____Organization retired from:_____

☐ **2 Year General or Associate Membership:** This only applies to General and Associate Membership Categories. **Dues are $115.**

☐ **$_____ Yes!** Please add the following tax deductible donation to the ASCT Foundation

Payment Method: _____Check (made to ASCT) _____MasterCard _____Visa _____AMEX

Authorized Cardholder:_____

Card Number:_____ Expiration Date: _____

Signature:_____

Please mail completed application to:
The American Society for Cytotechnology, 1500 Sunday Drive, Suite 102, Raleigh, NC 27607
Fax : 919-787-4916 or Email to: info@asct.com
Please allow three weeks for processing.
www.asct.com