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.*

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 **$50 per year**.
- ☐ **Student Membership**: open to students enrolled in approved schools of cytotechnology. A letter from the school (including completion date) is required. Upon graduation, current student members can renew at the same discounted rate of $20, for their first year of employment. Student membership dues are **$20 per year**.
- ☐ **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 **$50 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 $95.**

Payment Method: ________Check (made to ASCT) ________MasterCard ________Visa

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
Or Fax to: 919-787-4916 or Email to: info@asct.com
Please allow three weeks for processing.

Revised 07/10