TRAINEE

MEMBERSHIP APPLICATION FORM

OHIO SOCIETY OF PATHOLOGISTS

Name: _____

Degree: M.D. ____ D.O. ____ Ph.D. ____ Other ____ Date received: _____
Degree From: _____

Home Address: _____
_____
_____

Home Phone: _____

Present Position: _____
Program Address: _____
_____

Business Phone: _____ (FAX) _____

Email: _____

Residency/Fellowship Training in Pathology

PGY (ex: 1-4)	Year (ex: 2012-2013)	Institution

Trainee Signature, OR submit an electronic signature by placing an X in the following box and typing your name on the line below. ☐

_____ Date: _____

Signature of Program Director, OR submit an electronic signature by placing an X in the following box and typing your name on the line below. ☐

_____ _____ Date: _____
Print Signature

Please Return Completed Forms to**:** **Ohio Society of Pathologists, Susan E. Porter, MD**
Hillcrest Hospital, Pathology 2nd Floor Atrium
6780 Mayfield Road
Mayfield Heights, Ohio 44124

email: **veliaacampana@aol.com**