



Application for Membership

- New**
- Renewal**

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Name:		
Address	City	State	Zip
Phone	Email		

Please Check off your area:

- | | | |
|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Dallas | <input type="checkbox"/> San Antonio | <input type="checkbox"/> South Texas |
| <input type="checkbox"/> Houston | <input type="checkbox"/> East Texas | <input type="checkbox"/> Central Texas (Austin, Waco) |
| <input type="checkbox"/> Fort Worth | <input type="checkbox"/> West Texas | <input type="checkbox"/> S.E. Texas (Gavelston, Beaumont) |

Education (new members):

College or University: _____ Date Graduated: _____

Cytotechnology School: _____ Date Graduated: _____

Qualifications for Membership:

- Registered CT (ASCP) Dues \$30
- Registry eligible (expect to take the exam on _____) Dues \$30
- Resident/Student in an approved School of Cytotechnology (will graduate on _____) Free!
- Physician (Specialty: _____) Dues \$35

Statement of Intent:

I wish to apply for membership in the Texas Society of Cytology. I understand that dues as specified above must be submitted with this application.

Date: _____ **Signature:** _____

Please forward this application to:

Texas Society of Cytology
PO Box 143811
Austin, TX 78714