



John P. McGovern Building
1515 Hermann Dr.
Houston, TX. 77004-7126

Application for Membership

NAME IN FULL: _____ DEGREE: _____ DATE: _____

OFFICE NAME: _____

OFFICE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ EMAIL: _____

MEMBERSHIP DESIRED: Active (\$200) Junior (\$75)

MEDICAL EDUCATION: _____ DATE OF GRADUATION: _____

GRADUATE TRAINING:

Internship: _____ Date: _____

Residency: _____ Date: _____

Fellowship: _____ Date: _____

POST GRADUATE ACTIVITIES: _____

SPECIAL INTERESTS AND ACTIVITIES IN PATHOLOGY: _____

SIGNATURES OF TWO ACTIVE MEMBERS OF HSCP:

1. _____

2. _____

Applicant's Signature: _____

Please remit this application and payment to the Houston Society of Clinical Pathologists by

Email: [LaCoya Boone@hcms.org](mailto:LaCoya_Boone@hcms.org) or Fax: 713-526-1434

www.houstonpathologists.org

Payment is due with your application.