



# APPLICATION FOR MEMBERSHIP

|   |  |  |               |
|---|--|--|---------------|
| NAME (LAST, FIRST, MIDDLE)  |  | SUFFIX (EG. M.D.)  | DATE OF BIRTH |
| HOME ADDRESS  |  |  |               |
| HOME CITY, STATE, ZIP CODE  |  |  |               |
| HOME PHONE  |  | EMAIL ADDRESS  |               |
| COMPANY NAME AND ADDRESS  |  |  |               |
| COMPANY CITY, STATE, ZIP CODE   |  |  |               |
| OFFICE PHONE  |  | OFFICE EMAIL   |               |
| FAX #   |  | GENDER <input type="checkbox"/> M <input type="checkbox"/> F |               |
| PLEASE INDICATE HOW YOU FOUND OUT ABOUT DPA: <input type="checkbox"/> DPA MEMBER <input type="checkbox"/> DPA WEBSITE <input type="checkbox"/> RELATED ASSOCIATION <input type="checkbox"/> OTHER |  |  |               |
| MEMBER'S NAME   |  | NAME OF ASSOCIATION  |               |

PROFESSIONAL INTERESTS (PLEASE LIST): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check the membership category for which you are applying:**

- INDIVIDUAL MEMBER** - I am an individual interested in the advancement of digital pathology..... \$270.00
- CORPORATE MEMBER** - I belong to an organization that currently sponsors the DPA ..... \$100.00
- RESIDENT MEMBER** - I am a currently enrolled in a training program leading to certification by the American Board of Pathology ..... \$50.00
- RETIRED MEMBER** - I am a physician but have retired from practice ..... \$50.00

**PLEDGE OF MEMBERSHIP**

The Digital Pathology Association (DPA) symbolizes the highest standards in the teaching of, research in, and practice of digital pathology. In accepting membership in the DPA I agree to foster and advance the principles and objectives and to abide by the decision of the Executive Committee and the constitution and By-Laws of the Association. Also, I certify that the information given above is correct to the best of my knowledge.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

**PAYMENT AND FEES**

AMOUNT DUE \$ \_\_\_\_\_  CHECK # \_\_\_\_\_

CREDIT CARD:  VISA  MASTERCARD  AMERICAN EXPRESS

CREDIT CARD NUMBER \_\_\_\_\_ EXP. DATE \_\_\_\_\_

NAME (AS IT APPEARS ON CARD) \_\_\_\_\_

AUTHORIZED SIGNATURE \_\_\_\_\_

UPON COMPLETION, SEND APPLICATION WITH PAYMENT TO:

Digital Pathology Association  
 1360 Park Center Drive, Vista, CA 92081

866.478.4111 • 760.539.1164  
 info@digitalpathologyassociation.org