

# American Society for Mohs Histotechnology

## Membership Application

12/06

Please print or type.

Name: \_\_\_\_\_

First

MI

Last

Choose preferred greeting:  Mr.  Ms.  Mrs.  Dr.

Gender:  Male  Female Birth Date: \_\_\_\_\_

Name of ACMMSCO (Mohs College) Physician Who Supervises Mohs Histotechnology Procedures (Required for membership): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Office Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please send Society mail to:  Office Address **OR**  Home Address

### Employment Status - Please check appropriate box.

Full Time  Part Time (Hours/week: \_\_\_\_\_)  Student (Fellow)  Retired  
 Presently Unemployed  Other (Please identify): \_\_\_\_\_

### Position - Please check appropriate box and circle your degrees/credentials.

Technician\*  Nurse (RN, LPN) Other: \_\_\_\_\_

\*If you are a registered Histotech (HT or HTL), upon applying for membership, you are required to provide either your certification number or a copy of your certificate. Membership applications will not be processed without this information.

As a technician, do you have a certification? If so, please indicate below. Certification is not required for membership.

HT  HTL  
 Certificate Number: \_\_\_\_\_ OR  
 Copy of Certificate enclosed

### Indicate Method of New Member Dues Payment (\$150.00) Below:

Check enclosed payable to: ASMH  
 Credit Card - Check one →  MasterCard  Visa  American Express  
Card Number: \_\_\_\_\_ Exp. Date (MM/YY): \_\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this application form, with dues payment of \$150.00 to:

**American Society for Mohs Histotechnology**

**555 East Wells Street, Suite 1100**

**Milwaukee, WI 53202**

**Fax: (414) 276-3349**

**Please note: New Members pay \$150 dues payment for the first calendar year. Dues renewal is \$125 for each calendar year thereafter.**