New York State Histotechnological Society
Application for Membership

Contact Information: *Please check one* Office:_____ Home:_____

First Name:_____ Last Name:_____

Institution/Company:_____

Department:_____

Street Address 1:_____

Street Address 2:_____

City:_____

State:_____ Zip:_____

Home/Cell Phone:_____ Work Phone:_____

Email:_____

Demographics:

Nature of Work: *please check one*

Clinical:_____ Research:____ Education:___ Student:_____

Education (highest level attained):_____

ASCP Board Certification: HT:___ HTL:__ MT:___ MLT:__ Other:_

Membership Runs from July 30th to June 1st of the calendar year.

Membership dues are tax deductible.

Please select Membership:

New member:_____Annual fee $25.00 Referred By:_____

Renewal:____Annual Fee $25.00 Date of previous membership:_____

Student:_____Annual Fee $7.00 College:_____ Director:_____

Amount Enclosed:_____

Please make check or money order payable to:

New York State Histotechnological Society (NYSHS)
Send check and completed application to:
Christine Miller
PO box 16812
Rochester, NY 14616