



**Ohio Society of Pathologists
MEMBERSHIP APPLICATION FORM**

Name: _____

Degree: M.D. ____ D.O. ____ Ph.D. ____ Other ____

Degree From: _____

Home Address: _____

Home Phone: _____

Present Position: _____

Address: _____

Business Phone: _____ (FAX) _____

Email: _____

Year of Medical School Graduation: _____

Residency Training in Pathology (including Fellowships)

Certification American Board of Pathology:

Anatomic Pathology Yes ____ No ____ Date _____

Clinical Pathology Yes ____ No ____ Date _____

Other (Specify) _____ Date _____

Experience in Pathology (Post Residency)

Place

Dates

Proportion of time devoted to Pathology: _____

Specific Interests in Pathology: _____

Other Professional Society Memberships: _____

Signature: _____ Date: _____

Please Return Completed Forms to:

Ohio Society of Pathologists, Susan E. Porter, MD

Hillcrest Hospital, Pathology 2nd Floor Atrium

6780 Mayfield Road

Mayfield Heights, Ohio 44124

Email: veliaacampana@aol.com

Website: <https://pathology.osu.edu/osp/osp.html>