6816 Southpoint Pkwy., Ste 1000
Jacksonville, FL 32216
Phone: 904-309-6261 Fax: 904-998-0855
www.flpath.org

APPLICATION FOR MEMBERSHIP

Name____ Degree(s)______________

Date of birth (mm/dd/yy)________________________ ☐ Male ☐ Female

Job Title(s)____

____

CONTACT INFORMATION

Email Address______________________________ Website____________________________

Business Name____

Address____ State______ Zip________

Home Address____ State______ Zip________

Home Phone_____________________________ Business Phone__________________________

Mailing Preference ☐ Home ☐ Business

TYPE OF MEMBERSHIP

☐ **Regular Member: $450**

Physicians residing in the state of Florida who are licensed to practice medicine as an M.D. or D.O. in the state of Florida. Regular members must dedicate a major portion of their practice to Pathology, and must either be Diplomates of the American Board of Pathology or eligible for admission to the examination of that Board, as certified by said Board.

☐ **New Practitioner: $300** (CHOOSE ONE)

____ **First Year** ____ **Second Year**

Physicians who are in their first or second year of practice may join FSP in this category. It is noted that beginning third year of practice, the membership dues amount will increase to $450.

☐ **Resident Members: $0**

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ANTICIPATED YEAR OF COMPLETION

Resident Members shall be physicians in the State of Florida who are in a full time approved training program in Pathology or sub-specialty of Pathology.

☐ **Group Regular Members: $400**

(Same description as Regular Members with following exceptions)

Physician must belong to a group of at least 25 or more pathologists from the same facility that are members of FSP.

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NAME OF FACILITY

☐ **Corresponding Members: $350**

Corresponding Members shall include physicians who are practicing Pathology whose primary practice is in a State other than Florida, and is a member in good standing of a State society of pathology, other than the Florida Society of Pathologists. They shall have no vote at general or special meetings.

EDUCATION HISTORY

Medical or Graduate School	Location	Degree	Year Completed
Residency (Postgraduate Training)	Location	Degree	Year Completed
Fellowship (Postgraduate Training)	Location	Degree	Year Completed
Other Postgraduate Training	Location	Degree	Year Completed

BOARD CERTIFICATIONS

AP__________ Date______ CP__________ Date______ APCP__________ Date______

Other Board Name__________________________ Year Eligible_______ Year Certified_______

Florida License #______________________ In Effect and Unqualified? ☐ Yes ☐ No

If not in effect, please explain____

TEACHING AND/OR HOSPITAL APPOINTMENTS AND SOCIETY MEMBERSHIPS

Hospital or Medical School Name and Location	Dates
Hospital or Medical School Name and Location	Dates

MEDICAL SOCIETY MEMBERSHIPS

AMA ☐ Yes ☐ No CAP ☐ Yes ☐ No

County Medical Society Other Medical Society

I hereby make application for membership in the Florida Society of Pathologists. I agree to abide by all of the rules and regulations of the Constitution and bylaws and such changes and amendments as may hereafter be properly adopted, to revocation of membership in the event that any of the statements hereinafter made by me are false. I hereby pledge myself to the highest ethical standard in the practice of pathology, and, if elected to membership in the Florida Society of Pathologists, shall conduct myself in conformity with the Principles of Medical Ethics of the American Medical Association. By providing your email address you agree to accept valuable membership information sent electronically.

Applicant's Signature____ Date__________

OPTIONAL POLITICAL COMMITTEE (PC) DONATION

☐ One-time Political Committee (PC) Donation ☐ $1,000 ☐ Other $_______

☐ Monthly (1 Year) PC Donation ☐ $100 ☐ Other $_______

PAYMENT INFORMATION

Total Payment__________ Check #___________ ☐ Visa ☐ MasterCard ☐ AmEx

Name on Card______________________ Card #__________________________ Exp________

Signature____