



Request for Continuing Education Certificates

Contact Information:

Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Country: _____ Phone: _____

Email: _____ Fax: _____

Event Information:

- Current Year
- Multi - Year

Event(s) Attended:

NSH Symposium/Convention: Year(s): _____

NSH Summer Symposium: Year(s): _____

NSH Teleconferences: Month (s): _____

Other NSH Events: _____

Non NSH Events (State Meeting, Vendor training etc)

Meeting Name/Date/Location: _____

Meeting Name/Date/Location: _____

Meeting Name/Date/Location: _____

Payment Information:

Members: FREE

Non-Members: - \$100.00 per transcript for the current calendar year
- \$160.00 per transcript for multiple years

___ Check (enclosed)

___ Charge my credit card: ___ VISA ___ MC ___ AMEX

Card Number: _____ Exp Date: _____

Name on Card: _____ Signature: _____

** If you would like to become a member, please submit the included application.**



2009 MEMBERSHIP APPLICATION
JANUARY 1 - DECEMBER 31

NATIONAL SOCIETY FOR HISTOTECHNOLOGY
10320 Little Patuxent Parkway, Suite 804, Columbia, MD 21044
PHONE: 443-535-4060 FAX: 443-535-4055 WEB: www.nsh.org

Source: ONLINE PDF

TYPE OF MEMBERSHIP:

RENEWAL NEW MEMBER : PROFESSIONAL STUDENT RETIRED INTERNATIONAL

Program Director/Supervisor Name(required for Student Status Only):

MEMBERSHIP YEAR RUNS FROM JANUARY 1 TO DECEMBER 31. RENEWAL NOTICES ARE SENT IN OCTOBER FOR FOLLOWING YEAR

MEMBER NAME:

HOME ADDRESS:

ADDRESS:

CITY:

PROVINCE/STATE: ZIP/POSTAL CODE:

COUNTRY:

HOME TELEPHONE:

PERSONAL EMAIL:

WORK ADDRESS:

COMPANY:

DEPARTMENT:

TITLE:

ADDRESS:

CITY: PROVINCE/STATE:

ZIP/POSTAL CODE: COUNTRY:

TELEPHONE: FAX:

WORK EMAIL:

Referred by NSH Member:

State Histology License Number (if applicable)

MAIL PREFERENCE
Please Note: All NSH Correspondance will be sent to this address. In addition this address is published in our online membership directory.
HOME ADDRESS WORK ADDRESS

MEMBER DEMOGRAPHICS:

Date of Birth: Gender: Female Male Year entered Profession:

CHECK ALL APPLICABLE BOXES:

HT (ASCP) HTL (ASCP) MT (ASCP) CT (ASCP) SLS (ASCP) QIHC (ASCP)

RT ART MLT NOT CERTIFIED OTHER

HIGHEST LEVEL OF EDUCATION:

AA BABS MAMS PHD MD DWM OTHER

I PRACTICE HISTOLOGY IN(CHOOSE ONE):

Botany Clinical:Hospital Clinical:University Clinical:Private Lab EM Industry

Marine Research Veterinary

PAYMENT: Remit fee with completed application in US funds to the NSH Office: 10320 Little Patuxent Pkwy, Suite 804, Columbia, MD 21044.

Circle Membership Dues: \$80.00 (2009 Professional/Intl) \$40.00 (2009 Student/Retired)

Circle Membership Pin (\$10.00): Yes No Thanks

Optional ADA Fund Contribution \$ (Your donation to the ADA will aid in furthering the education of the physically challenged.)

Total Due \$

A check for the total amount due payable to NSH is included with this application.

Please charge my Visa, MasterCard or American Express for the Total Due listed above.

Card Holder's Name: Card Holder's Signature:

Card Number: Expiration Date: