AUSTRALIAN SOCIETY OF CYTOLOGY INC

ABN 76 001 239 606

APPLICATION FOR MEMBERSHIP

TITLE: Prof / Dr / Mrs / Ms / Miss / Mr	SURNAME: PLEASE USE BLOCK LETTERS
GIVEN NAMES:	DOB: / /
LABORATORY:	
PREFERRED ADDRESS:	
	POSTCODE:
BH PHONE:	MOBILE:
EMAIL:	

QUALIFICATIONS *Please attach copies to your application*	INSTITUTION	YEAR
AHPRA registration number:	*(will be accepted instead of copies of qualifications)*	

PROPOSER AND SECONDER (must be either Medical or Non-Medical financial members of the Society).

PROPOSER:	SIGNATURE:
SECONDER:	SIGNATURE:

MEDICAL	Registered medical practitioners who engage in the practice of Cytology.	Specialist	220.00	
		Registrar	220.00	
NON MEDICAL	Graduates of a degree course in Medical Laboratory Science (or its equivalent) from a recognised tertiary institution or persons who hold the CT(ASC) or an equivalent qualification, who are not registered medical practitioners but who engage in the practice of Cytology.		220.00	
	Do you intend to undertake the CTASC in the future? Yes ☐ No ☐ Which exam will you undertake? Gynae ☐ year..... Non-Gynae ☐ year..... or Both (same year) ☐ year.....			
ASSOCIATE	Persons interested in Cytology not eligible to be Medical or Non-Medical members. Associate members do not have the right to vote in the affairs of the Society, but may participate in all other activities of the Society.		143.00	
	JOINING FEE *(if lapsed member of < 5 years please delete)*		55.00	55.00
	Electronic copies of Cytoletter are included in membership **TOTAL**		**(inc GST)**	$

SIGNATURE:	DATE: / /

PAYMENT DETAILS: Enclose Cheque or Money Order made payable to Australian Society of Cytology Inc. **OR**

Debit my Visa/Mastercard Card Verification Code___/___/___ **For $**_____

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry ☐☐/☐☐

Name on card:_____ Signature on card: _____

Return this form to: Australian Society of Cytology Inc or admin@cytology.com.au
PO Box 52
HENLEY BEACH SA 5022

UPDATED OCTOBER 2025