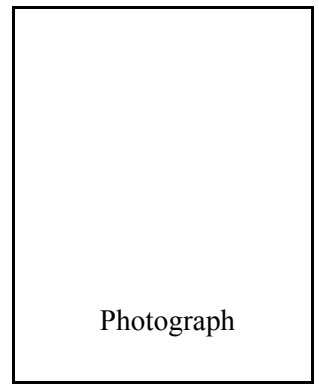


**THE INTERNATIONAL ACADEMY OF CYTOLOGY
OFFICE OF THE SECRETARY GENERAL
Massimo Bongiovanni M.D, F.I.A.C.**

MAIL ADDRESS:

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APPLICATION FOR PROFESSIONAL NON-MEDICAL MEMBERSHIP

INSTRUCTIONS FOR APPLICANTS

(The I.A.C. Constitution & Bylaws can be viewed on the Internet: www.cytology-iac.org)

1. Type all information, complete all sections and use additional sheets if necessary
2. Enclose all letters of recommendation
3. Enclose copy of university degree
4. Secure sponsorship signatures of two fellows or members of the Academy (page 4)
5. Sign statement (page 4) and enclose a passport size photograph
6. Application fee is Euro 140 and Annual Membership fee (Jan-Dec) is Euro 190 payable on-line at the link below:
Select "Application Fee Profession Non-Medical Member"

Link: <https://www.cytology-iac.org/members-area/iac-application-form/>

NAME	Given first name			Middle		Family name		
DATE OF BIRTH	Month	Day	Year	Country of birth		Present citizenship		
WORK ADDRESS (Correct postal address)	Current position, if Hospital or Medical Center include name of Institution							
	Street				Town/City			
	State(if necessary)				Postal code			
	Country							
	Work telephone:				Work fax:			
HOME ADDRESS (Correct postal address)	Street				Town/City			
	State(if necessary)				Postal code			
	Country							
	Home telephone:				Home fax:			
E. MAIL								
ACADEMY CORRESPONDENCE				Please send to: HOME <input type="checkbox"/>		WORK <input type="checkbox"/>		
JOURNAL "ACTA CYTOLOGICA"				Please send to: HOME <input type="checkbox"/>		WORK <input type="checkbox"/>		

Do not write below – official space only

Received:	Letters of recommendation:	Sent to: Membership Committee:	Action by Executive Council:	Diploma dated:
Fee & dues:	Sponsors:	Action by: Membership Committee:	Acceptance:	Diploma sent:

E D U C A T I O N

Mandatory requirement:

University degree, other than medical in country of residence

UNIVERSITY DEGREE	Year	School
	City/Town	Country
	I graduated in (subject): <i>Please include copy of diploma</i>	
	(Place)	(Date)
TRAINING IN CYTOPATHOLOGY OR CLINICAL CYTOLOGY (Full-time only)	Institution	Director
	City/Town	Country
	from	to
	Institution	Director
	City/Town	Country
	from	to
	Institution	Director
	City/Town	Country
	from	to
	Institution	Director
	City/Town	Country
	from	to

<p>EXPERIENCE IN</p> <p>CYTOPATHOLOGY</p> <p>OR</p> <p>CLINICAL</p> <p>CYTOLOGY</p> <p>additional sheets may be used</p>	Hospital	City/Town
	from	to
	Hospital	City/Town
	from	to
	Hospital	City/Town
	from	to
	Hospital	City/Town
	from	to

PUBLICATIONS
(Separate sheets may be used)

Large empty rectangular area for listing publications.

LETTERS OF RECOMMENDATION

List the names and addresses of two (2) physicians who will recommend you for admission to the International Academy of Cytology and who will attest to your character and professional standards. These physicians **do not** necessarily need to be Fellows or Members of the Academy nor your application sponsors.

NAME	
INSTITUTION/ UNIVERSITY	
ADDRESS	
NAME	
INSTITUTION/ UNIVERSITY	
ADDRESS	

SPONSORS

Names and signatures of two (2) *MEMBERS* or *FELLOWS* of the ACADEMY sponsoring your application

NAME IN FULL	
SIGNATURE	<small>Date</small>
NAME IN FULL	
SIGNATURE	<small>Date</small>

APPLICATION STATEMENT TO BE SIGNED BY APPLICANT

I desire to become a Member of the International Academy of Cytology, and, if elected by the Executive Council, I hereby promise that, so long as I continue to be a member of the Academy, I will, to the utmost of my power, promote the honor and interest of the said academy and observe the enactments of its constitution and bylaws, both as they are now and as they may be altered from time to time.

Date:

Signature: