# ASCP CYTOLOGY ASSESSMENT

**By Fax:**
Fax to **317.569.0221**
and transmit a copy of
your purchase order.

**By Phone:**
**317.569.9470**
Monday–Friday (8am–5pm ET)
(Outside the US 312.541.4848)
Please have credit card
information ready.

**By Mail:**
ASCP
3462 Eagle Way
Chicago, IL 60678-1034
Include check payable to ASCP
or purchase order.

☑ **YES! Please renew my Cytology Assessment subscription for 2021 as indicated.**

| Cytopathology Assessment Program | Price | Quantity | # of Participants | Quantity x Price |
|---|---|---|---|---|
| ☐ **NonGYN Assessment** (NGYN21-GLASS) | $_______ | _______ | _______ | $_______________ |
| ☐ **NonGYN Digital** (NGYN21-DIGITAL) | $_______ | _______ | _______ | $_______________ |
| ☐ **NonGYN Virtual** (NGYN21-VIRTUAL) | $_______ | _______ | _______ | $_______________ |
| ☐ **GYN Assessment** (GYN21-GLASS) | $_______ | _______ | _______ | $_______________ |
| ☐ **GYN Virtual** (GYN21-VIRTUAL) | $_______ | _______ | _______ | $_______________ |

Total # of participants _______ x $_______ per program = $ _______________

**For GYN, select prep type:**

☐ All SurePath

☐ All Thin Prep

**Bundle Discount** $ _______________

Bundle discount (-$75) applied if both GYN and NonGYN programs are purchased.

**Grand Total** **$**

**Participant Name**

**SHIP CUSTOMER #** **BILL CUSTOMER #**

**Please verify your shipping and billing information.** Indicate any changes.

**SHIPPING ADDRESS:**

**BILLING ADDRESS:**

Purchase Order Number (please attach a copy of the purchase order) _______________

Contact Person _______________

**E-mail (required)** _______________

Phone _______________ Fax _______________

☐ I want to pay by credit card. Please call me at _______________

Date/Time _______________

CY1-CS-21-WEB