

**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 2024 as indicated.

Series Selection	Price/Program	Quantity	# of Participants/Program	Program Price x Quantity
<input type="checkbox"/> NonGYN Assessment (NGYN24-GLASS)		_____	_____	\$ _____
<input type="checkbox"/> NonGYN Digital (NGYN24-DIGITAL)		_____	_____	\$ _____
<input type="checkbox"/> NonGYN Virtual (NGYN24-VIRTUAL)		_____	_____	\$ _____
<input type="checkbox"/> GYN Assessment (GYN24-GLASS)		_____	_____	\$ _____
<input type="checkbox"/> GYN Virtual (GYN24-VIRTUAL)		_____	_____	\$ _____

Total # of participants \_\_\_\_\_ x \$ \_\_\_\_\_ per program = \$ \_\_\_\_\_

**For GYN, select prep type:**

All SurePath

All Thin Prep

**Assessment Program Subtotal:** \$ \_\_\_\_\_

**Bundle Discount:** \$ \_\_\_\_\_

**Grand Total:** \$ \_\_\_\_\_

If both GYN and NonGYN programs are purchased, apply bundle discount (-\$75)

**Participant Name**

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## ASCP will follow up for participant information.

<b>SHIP CUSTOMER #</b>	<b>BILL CUSTOMER #</b>
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**Please verify your shipping and billing information. Indicate any changes.**

<b>SHIPPING ADDRESS:</b>	<b>BILLING ADDRESS:</b>	Purchase Order Number (please attach a copy of the purchase order) _____
		Contact Person _____
		<b>E-mail (required)</b> _____
		Phone _____ Fax _____

**IMPORTANT!** For your protection, ASCP no longer gathers credit card info via mail or fax. Please call to give ASCP your credit card information.

I want to pay by credit card. Please call me at \_\_\_\_\_  
 Date/Time \_\_\_\_\_