ASCP **GYN PT**

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.

Series Selection	Price	Quantity	# of Participants	Quantity x Price
☐ GYN Proficiency Testing 2026 (PT26-GLASS)	$1,199.00	_____	_____	$_____
☐ GYN PT and Lab Comparison 2026 (PTLC26) *(GYN PT + one shipment of 12 high-quality glass slides with comparative results & statistics)*	$1,599.00	_____	_____	$_____
		PARTICIPATION FEE (PT-GLASS-PART): Total # of Participants for PT _____ x $119		$_____
		RECORDING FEE (PTCLIA26) for each additional CLIA GYN Certificate _____ x $500		$_____
			Grand Total	$_____

Please mark your desired day to ensure your preferred testing.

2026 1.☐☐/☐☐ 2.☐☐/☐☐

If choosing PT & Lab Comparison*, please indicate in order of preference your date for the single shipment of Lab Comparison:

2026 1.☐☐/☐☐ 2.☐☐/☐☐

Prep Type: ☐ **ThinPrep** ☐ **SurePath** ☐ **Conventional**

Please indicate the anticipated total number of screeners for the Prep Type Selected Above.

☐ **Primary Screeners** ☐ **Secondary Screeners**

Please select the OPTION you wish to use for your 2026 GYN PT test:

☐ **Online GYN PT Proctor Portal** (same day results)

☐ **Manual GYN PT process** (results within 7 business days)

CAP Accreditation #:

(If using for CAP LAP purposes):

CLIA #:

Lab Director Name:

Proctor #1 Name:

Proctor Phone: **Fax:**

Proctor Email:

ASCP will follow-up for additional proctor and participant information.
ASCP Proctors are available for an additional fee.

**Lab Comparison is only one way to meet CAP LAP accreditation requirements, and offers up to 6.0 CME/CMLE credits. For a more in-depth education program, consider ASCP GYN Assessment. For more information, check the web at ascp.org.*

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

Contact Person Email (required)

Accounts Payable Email (required)

Phone Fax

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

Date/Time _____

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