

RSNA[®]

Membership Application

The Radiological Society of North America (RSNA[®]) is a professional membership organization devoted to developing the highest standards of radiology and related sciences through education and research.

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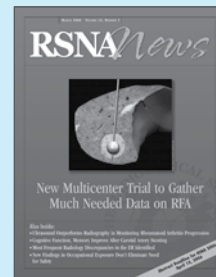
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Membership Application

Approved Disapproved

RCVD _____ ACKN _____

Rec Date: ACCTG _____ DM _____ MBR _____

RTG _____ ADM (Mo/Day/Year) _____

Member Number _____

Please type or print

1. **First Name:** _____ **Middle:** _____

Last Name (Family name): _____ **Generation (Sr., Jr., II, III, IV):** _____

Degrees to be published (Max. of 2): _____

Birthdate (Mo/Day/Year): _____ Male Female

Spouse/Partner's name: _____ Prefix: _____

Specialty: _____ Hospital Setting Academic Setting Private Practice
(i.e., diagnostic radiology, radiation oncology, medical physics)

2. **Where do you prefer to receive your journals and correspondence?** Home Office

3. **Address:**

(If you indicate an office address, be sure to supply the institution name and department)

City: _____ State or Province: _____ Zip (Zip+4) Postal Code: _____

Country: _____

4. **Contact Information:**

Home Phone: _____ E-mail: _____

Office Phone: _____ Ext. _____ Fax: _____

5. **If you are board certified, please specify:**

Board: _____ Year: _____
(ABR, ABMP, ABNM, AOCC, FRCP®, Consejo Mexicano de Radiología e Imagen, FRCR, JBR, other)

6. **Medical Education/University:**

Medical School: _____

City: _____ State or Province: _____ Country: _____

From (Month/Year): _____ To (Month/Year): _____ Medical Degree: _____

7. **Graduate Education (M.Sc. or Ph.D.):**

Graduate School: _____

City: _____ State or Province: _____ Country: _____

From (Month/Year): _____ To (Month/Year): _____ Graduate Degree: _____

8. Residency Training in Radiology:

Institution: _____

City: _____ State or Province: _____ Country: _____

Director's Full Name: _____

From (Month/Year): _____ To (Month/Year): _____ Date of Completion of Residency: _____

9. Fellowship:

Institution: _____

City: _____ State or Province: _____ Country: _____

Director's Full Name: _____

From (Month/Year): _____ To (Month/Year): _____ Date of Completion of Fellowship: _____

10. Subspecialty Areas of Interest: Mark **one** circle to indicate primary specialty. Mark **all** applicable squares for areas of interest.

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Breast/Mammography | <input type="checkbox"/> <input type="checkbox"/> Cardiac Radiology | <input type="checkbox"/> <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> <input type="checkbox"/> Chest | <input type="checkbox"/> <input type="checkbox"/> Computed Tomography | <input type="checkbox"/> <input type="checkbox"/> Diagnostic Radiology |
| <input type="checkbox"/> <input type="checkbox"/> Emergency Radiology | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> <input type="checkbox"/> General |
| <input type="checkbox"/> <input type="checkbox"/> Genitourinary | <input type="checkbox"/> <input type="checkbox"/> Head & Neck | <input type="checkbox"/> <input type="checkbox"/> Health Policy & Practice |
| <input type="checkbox"/> <input type="checkbox"/> Informatics | <input type="checkbox"/> <input type="checkbox"/> Magnetic Resonance | <input type="checkbox"/> <input type="checkbox"/> Molecular Imaging |
| <input type="checkbox"/> <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> <input type="checkbox"/> Neuroradiology | <input type="checkbox"/> <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> <input type="checkbox"/> OB/GYN | <input type="checkbox"/> <input type="checkbox"/> Pediatric Radiology | <input type="checkbox"/> <input type="checkbox"/> Physics |
| <input type="checkbox"/> <input type="checkbox"/> Professionalism | <input type="checkbox"/> <input type="checkbox"/> Quality Assurance | <input type="checkbox"/> <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> <input type="checkbox"/> Radiobiology | <input type="checkbox"/> <input type="checkbox"/> Research | <input type="checkbox"/> <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> <input type="checkbox"/> Vascular/Interventional | <input type="checkbox"/> <input type="checkbox"/> Wholebody Imaging | |

11. I agree to abide by the current bylaws and any revisions thereof:

I certify that the foregoing statements are true and complete to the best of my knowledge and belief, and understand that any willfully false statement is sufficient cause for rejection of this application or the termination of the membership.

Signature of Applicant

Date

RSNA CHARGE AUTHORIZATION FORM

Rates good through December 31, 2009
Print subscriptions begin with January issue.

Total Amount

Card Number

Month

Year

Expiration Date

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> VISA | <input type="checkbox"/> Discover |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Diners Club |
| <input type="checkbox"/> AMEX | |

Signature

Name as it appears on card

Checks must be drawn on a U.S. bank in U.S. dollars payable to RSNA. By sending your check to us, you authorize RSNA to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited the same day we receive your payment.

Mail to: RSNA
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Oak Brook, IL 60523-2251

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Fax: 1-630-571-7837
E-mail: membership@rsna.org