



Corresponding 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.

Corresponding Members are radiologists, radiation oncologists, medical physicists, nuclear medicine physicians and radiologic scientists. Corresponding Members also include dentists, non-radiologist physicians and veterinarians. Corresponding Members are provided with many valuable benefits, including:

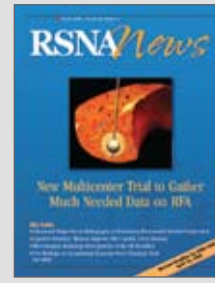
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RSNA 2010

PERSONALIZED MEDICINE:
In Pursuit of Excellence

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World-class Meeting

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Free opportunity for continuing education

... Plus much more. See RSNA.org/Membership/benefits.cfm



A personal homepage to store files, bookmarks and searches, accessible from any computer

Find out how RSNA is helping more than 44,000 of your colleagues maintain their professional edge.

Join today. Apply online at RSNA.org/apply.

Annual Membership Dues

Membership dues are established by the RSNA Board of Directors.
Dues must accompany application when submitted. RSNA dues are:

Corresponding Members

(Individual online only journal access) \$400.00
(Optional print journals added) \$490.00

Membership cycle runs January 1–December 31
Dues rates good through December 31, 2010

Instructions for Application

Complete the attached application. Please type or print.

Membership application must be received by September 1 in order to attend RSNA 2010 as a member.

- Fill in required information.
- Sign line 12.
- Forward your completed application, dues payment and updated **curriculum vitae** in English to RSNA at the address below.
- Or apply online at RSNA.org/apply.

Procedure for Admission

1. Once received, your application will be reviewed by RSNA.
2. New applicants' names will be published online for review by members.
3. You will be notified in 6–8 weeks about your membership status.

U.S. postage regulations require that we allocate a portion of membership dues to our journals. For Corresponding Members, the allocation is \$187.50 for *Radiology*, \$100.00 for *RadioGraphics* and \$10.00 for *RSNA News*. All members must pay full dues. No arrangements can be made for partial payment of dues.



Corresponding Membership Application

Please type or print

<input type="checkbox"/> Approved		<input type="checkbox"/> Disapproved	
RCVD _____	ACKN _____		
Rec Date: ACCTG _____	DM _____	MBR _____	
RTG _____	ADM (Mo/Day/Year) _____		
Member Number _____			

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: _____ (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. **Primary Practice Location:** Hospital Setting Academic Setting Private Practice

Primary Activity: Basic Research Clinical Teaching

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

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

7. **Medical Education/University:**

Medical School: _____

City: _____ State or Province: _____ Country: _____

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

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

Graduate School: _____

City: _____ State or Province: _____ Country: _____

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

9. Residency Training:

Institution: _____

City: _____ State or Province: _____ Country: _____

Director's Full Name: _____

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

10. Fellowship:

Institution: _____

City: _____ State or Province: _____ Country: _____

Director's Full Name: _____

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

11. Subspecialty Areas of Interest: Mark **one** to indicate primary specialty. Mark **all** applicable 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 | <input type="checkbox"/> <input type="checkbox"/> Other |

12. 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, 2010

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
820 Jorie Blvd.
Oak Brook, IL 60523-2251 U.S.A.

Phone: +1-630-571-7873
Fax: +1-630-571-7837
E-mail: membership@rsna.org