

PLEASE TYPE OR PRINT:

▶ **Associate Non-Physicians:** Please complete lines 1 through 3, 5, 6 (if applicable) and 10, review 11, complete 12

**1. Personal Information:**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name (Family Name) \_\_\_\_\_ Generation (Sr., Jr. II, III, IV) \_\_\_\_\_

Academic Degrees to be published, 2 maximum

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birthdate (Month/Day/Year)  Male  Female

Spouse/Life Partner's First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name (Family Name) \_\_\_\_\_ Prefix (Dr. Mr., Mrs. Ms.) \_\_\_\_\_

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

**2. Address:** (If you indicate an office address, be sure to provide the institution name and department)

Institution Name/Department \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State or Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

**3. Contact Information:**

Primary Phone \_\_\_\_\_ Preferred Email \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**4. If you are board certified, please specify:** Board \_\_\_\_\_ Year \_\_\_\_\_  
(ABR, ABMP, ABNM, AOCC, FRCR<sup>®</sup>, Consejo Mexican de Radiologia e Imagen, FRCR, JBRE, other)

**5. Medical Education/University:**

Medical/University School Name \_\_\_\_\_ Degree/Medical Degree \_\_\_\_\_

City \_\_\_\_\_ State or Province \_\_\_\_\_ Country \_\_\_\_\_ Begin Date (Month/Year) \_\_\_\_\_ Completion Date (Month/Year) \_\_\_\_\_

**6. Graduate Education:** (i.e., Master or Doctorate Degree)

Graduate School Name \_\_\_\_\_ Graduate Degree \_\_\_\_\_

City \_\_\_\_\_ State or Province \_\_\_\_\_ Country \_\_\_\_\_ Begin Date (Month/Year) \_\_\_\_\_ Completion Date (Month/Year) \_\_\_\_\_

**7. Residency Training in Radiology:**

Institution Name \_\_\_\_\_ Program Director's Full Name \_\_\_\_\_

City \_\_\_\_\_ State or Province \_\_\_\_\_ Country \_\_\_\_\_ Begin Date (Month/Year) \_\_\_\_\_ Completion Date (Month/Year) \_\_\_\_\_

**EMAIL, FAX OR MAIL REQUIRED COPY OF YOUR CURRICULUM VITAE**

**Active (Board-certified North America) \$525\***

Includes print and online journals  
Add 3D Printing Special Interest Group for \$40

**International Members \$525\***

Add print journals for \$90  
Add 3D Printing Special Interest Group for \$40

**Qualifications**

- Radiologists
- Radiation Oncologists
- Medical Physicists
- Nuclear Medicine Physicians
- Radiologic Scientists (Researchers/Bio-Medical Engineers)

**Associate (Board-eligible) \$525\***

Includes print and online journals  
Add 3D Printing Special Interest Group for \$40

**Qualifications**

- Radiologists
- Radiation Oncologists
- Medical Physicists
- Nuclear Medicine Physicians
- Radiologic Scientists
- Dentists
- Physicians (Non-Radiologist)
- Veterinarians
- Molecular Biologists
- Bio-Medical Engineers
- Computer Scientists

**Associate (Non-Physician) \$263\***

Add print journals for \$80  
Add 3D Printing Special Interest Group for \$40

**Qualifications**

- Administrators/Business Managers (Hospital/Radiology/Radiation Oncology)
- Architects
- Assistants (Physician/Radiologist)
- Educators
- Medical Dosimetrists
- Nurse Practitioners
- Radiation Therapists
- Radiographers
- Registered Nurses
- Sonographers
- Technologists (Radiologic/Nuclear Medicine)

\*Membership extends January 1 through December 31, regardless of join date.

**8. Fellowship:**

Institution Name: \_\_\_\_\_ Program Director's Full Name \_\_\_\_\_  
 City \_\_\_\_\_ State or Province \_\_\_\_\_ Country \_\_\_\_\_ Begin Date (Month/Year) \_\_\_\_\_ Completion Date (Month/Year) \_\_\_\_\_

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

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Breast Radiology     | <input type="checkbox"/> Emergency Radiology        | <input type="checkbox"/> Leadership & Management    | <input type="checkbox"/> Oncologic Imaging              | <input type="checkbox"/> Safety & Quality |
| <input type="checkbox"/> Cardiac Radiology    | <input type="checkbox"/> Gastrointestinal Radiology | <input type="checkbox"/> Magnetic Resonance Imaging | <input type="checkbox"/> Pediatric Radiology            | <input type="checkbox"/> Ultrasound       |
| <input type="checkbox"/> Chest Radiology      | <input type="checkbox"/> Genitourinary Radiology    | <input type="checkbox"/> Molecular Imaging          | <input type="checkbox"/> Physics & Basic Science        | <input type="checkbox"/> Vascular         |
| <input type="checkbox"/> Computed Tomography  | <input type="checkbox"/> Head & Neck                | <input type="checkbox"/> Musculoskeletal Radiology  | <input type="checkbox"/> Professionalism                | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Health Policy & Practice   | <input type="checkbox"/> Neuroradiology             | <input type="checkbox"/> Radiation Oncology             |   |
| <input type="checkbox"/> Digital Mammography  | <input type="checkbox"/> Informatics                | <input type="checkbox"/> Nuclear Medicine           | <input type="checkbox"/> Radiobiology                   |   |
| <input type="checkbox"/> Education            | <input type="checkbox"/> Interventional             | <input type="checkbox"/> OB/GYN                     | <input type="checkbox"/> Research & Statistical Methods |   |

Please Select One:  Academic Setting  Private Practice  Other

**10. Practice Location:**

University \_\_\_\_\_ Name of University \_\_\_\_\_ City \_\_\_\_\_ State or Province \_\_\_\_\_  
 Hospital \_\_\_\_\_ Name of Hospital \_\_\_\_\_ City \_\_\_\_\_ State or Province \_\_\_\_\_  
 Freestanding \_\_\_\_\_ Name of Practice \_\_\_\_\_ City \_\_\_\_\_ State or Province \_\_\_\_\_

**11. Professional Licensure for Associate Members:**

Must be eligible or provide a copy of member verification in one of the following RSNA Associate Sciences Consortium organizations.

**ARCHITECTS, EDUCATORS, HOSPITAL AND RADIOLOGY ADMINISTRATORS, RADIOLOGY BUSINESS MANAGERS, RADIOLOGIST ASSISTANTS, RADIOLOGIC TECHNOLOGISTS**

- American Institute of Architects-Academy of Architecture for Health (AIA-AAH)
- American Society of Radiologic Technologists (ASRT)
- Association of Educators in Imaging and Radiologic Sciences, Inc. (AEIRS)
- Association for Medical Imaging Management (AHRA)
- Association of Vascular and Interventional Radiographers (AVIR)
- Canadian Association of Medical Radiation Technologists (CAMRT)
- College of Radiographers (CoR)
- International Society of Radiographers & Radiological Technologists (ISRRT)
- Radiology Business Management Association (RBMA)
- Section for Magnetic Resonance Technologists-International Society for Magnetic Resonance in Medicine (SMRT-ISMRM)
- Society of Nuclear Medicine Technologists Section (SNMTS)

**Certification:**

Please provide a current copy of certificate from one of the following:

**DENTISTS**

American Board of General Dentistry

**MEDICAL DOSIMETRISTS**

Medical Dosimetrist Certification Board

**REGISTERED NURSES, NURSE PRACTITIONERS**

Current copy of appropriate state board of nursing licensure

**PHYSICIANS, PHYSICISTS, RADIOLOGIC SCIENTISTS (board eligible)**

American Osteopathic Board of Radiology  
 American Board of Oral and Maxillofacial Radiology  
 Member boards of the American Board of Medical Specialties

**PHYSICIAN ASSISTANTS**

National Commission on Certification of Physician Assistants

**SONOGRAPHERS**

American Registry for Diagnostic Medical Sonography

**VETERINARIANS**

American College of Veterinary Radiology

**12. I agree to abide by the current bylaws and any revision 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.

**X** \_\_\_\_\_ Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Opt for online only journals  Radiology  Radiographics  RSNA News By opting for online publications only, you will not receive print copies of the publication(s) indicated.

**RSNA Charge Authorization Form Rates valid through December 31, 2017**

Select One Category: See reverse side for category qualification

- |   |   |
|---|---|
| <input type="checkbox"/> Active (Board-certified North America) \$525 | <input type="checkbox"/> Associate (Board-eligible) \$525 |
| <input type="checkbox"/> International Members \$525                  | <input type="checkbox"/> Associate (Non-Physician) \$263  |
| <input type="checkbox"/> Add print journals for \$90                  | <input type="checkbox"/> Add print journals for \$80      |
| <input type="checkbox"/> Add 3D Printing Special Interest Group \$40  |   |

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** TEL 1-877-RSNA-MEM Outside of U.S. & Canada 1-630-571-7873  
 820 Jorie Blvd. FAX 1-630-571-2198  
 Oak Brook, IL 60523-2251 [membership@rsna.org](mailto:membership@rsna.org)

- Check # \_\_\_\_\_  Amex  Diner's Club  Discover  Mastercard  Visa

**AUTOMATIC MEMBERSHIP RENEWAL**

Yes, automatically renew my membership dues payment beginning in 2018

Total Amount \_\_\_\_\_ Expiration Date (Month/Year) \_\_\_\_\_  
 \_\_\_\_\_  
 Card Number \_\_\_\_\_

\_\_\_\_\_  
 Name as it appears on card

**X** \_\_\_\_\_  
 Cardholder Signature I authorize my credit card to be charged the total amount listed. If my fees are totaled incorrectly, RSNA will make the necessary adjustments and charge my credit card accordingly