RSNA®
Radiological Society of North America

MEMBER-IN-TRAINING AND MEDICAL STUDENT MEMBERSHIP APPLICATION

PLEASE TYPE OR PRINT:

- **Medical Students:** Please complete lines 1 through 5.
- **Residents/Fellows:** Please complete lines 1 through 4, 6 (*if applicable*) and 7 through 10.
- **Radiologic Scientist Students:** Please complete lines 1 through 3, 6, 9 (*if applicable*) and 10.

1. Personal Information:

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

Academic Degrees/Credentials 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 ______

4. Medical Education/University:

Medical School/University Name ______ Degree/Medical Degree ______

City ______ State or Province ______ Country ______

___ / ___
Begin Date (Month/Year)

___ / ___
Completion Date (Month/Year)

5. 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

X ______
Dean of Medical School Signature

Date ______

Date ______

Medical Student FREE*
Add print journals for $80
Add 3D Printing Special Interest Group for $40

Qualifications
- Be residing in North America and enrolled in a North American medical school approved by the Liaison Committee for Medical Education or its equivalent.

Member-in-Training / Residents & Fellows FREE*
Add print journals for $80
Add 3D Printing Special Interest Group for $40

Qualifications
- Physicians in an approved residency training program or subspecialty fellowship
- Radiologic scientist students in an approved training program or subspecialty fellowship

International Member-in-Training / Residents & Fellows FREE*
Add print journals for $170
Add 3D Printing Special Interest Group for $40

Qualifications
- Physicians in an approved residency training program or subspecialty fellowship
- Radiologic scientist students in an approved training program or subspecialty fellowship

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

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

Graduate School Name _______________ Graduate Degree _______________

City _______________ State or Province _______________ Country _______________ Begin Date (Month/Year) ____ / ____ Completion Date (Month/Year) ____ / ____

7. Residency Training in Radiology:

Please indicate training program (select one) ☐ Diagnostic Radiology ☐ Nuclear Medicine ☐ Radiation Oncology

Institution Name: _______________ Program Director's Full Name _______________

City _______________ State or Province _______________ Country _______________

Begin Date (Month/Year) ____ / ____ Anticipated Completion Date of Residency (Month/Year) ____ / ____

8. If you are board certified, please specify:

Board _______________ Year _______________

(ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexican de Radiologia e Imagen, FRCR, JBRE, other)

9. Fellowship:

Institution Name _______________ Program Director's Full Name _______________

City _______________ State or Province _______________ Country _______________

Begin Date (Month/Year) ____ / ____ Anticipated Completion Date of Fellowship (Month/Year) ____ / ____

10. 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

X _______________ Director of Current Residency/Fellowship Program Signature

Date _______________

Date _______________

RSNA Charge Authorization Form

Select One (Optional) Print Journal Category: *See reverse side for category qualification*

☐ Medical Student $80
☐ Resident/Fellow North America $80
☐ Resident/Fellow International $170
☐ Add 3D Printing - Special Interest Group $40

Rates valid through December 31, 2017

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

TEL 1-877-RSNA-MEM *Outside of U.S. & Canada* 1-630-571-7873
FAX 1-630-571-2198
membership@rsna.org

☐ Check #______ ☐ Amex ☐ Diner's Club ☐ Discover ☐ Mastercard ☐ Visa

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

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