	☐ Approved ☐ Disapproved
RCVD ____________	ACKN ____________
Rec Date: ACCTG ________	DM ______ MBR ______
RTG ____________	ADM (Mo/Day/Year) ________
Member Number ____________	

Membership Application

(Discounted Membership Dues Option)

Please type or print

First Name: ______________________ **Middle Name:** ______________________

Last Name (Family name): ______________________

Academic Degrees/Credentials to be published (Max. of 2): ______________________

Birthdate (Month/Day/Year): ___/___/___ ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer

Spouse/Life Partner's Name: ______________________ Prefix (Dr., Prof., Mr., Mrs., Ms.):_____
First Name Last (Family) Name

1. **Specialty:** ______________________ ☐ Academic Setting ☐ Private Practice ☐ Other
   (i.e., Diagnostic Radiology, Radiation Oncology, Medical Physics)
   Primary Activity: ☐ Basic Research ☐ Clinical ☐ Teaching (Please Select One)

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

3. **Address:**
   (If you indicate an office address, be sure to provide the institution name and department)
   ____
   ____
   City: ______________ State or Province: __________ ZIP/Postal Code: __________
   Country: ______________________

4. **Contact Information:**
   Home Phone: ______________________ Email: ______________________
   Office Phone: ______________ Ext. ___ Cell Phone: ______________ Fax: ______________
   (Please Select One)

5. **If you are board certified, please specify:**
   Board: ______________________ Year: __________
   (ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexicano de Radiologia e Imagen, FRCR, JBR, other)

6. **Medical Education/University:**
   Medical School Name: ______________________
   City: ______________ State or Province: __________ Country: __________
   Begin Date (Month/Year): ________ Completion Date (Month/Year): ________ Degree/Medical Degree: ______

7. **Graduate Education (i.e., Master or Doctorate Degree):**
   Graduate School Name: ______________________
   City: ______________ State or Province: __________ Country: __________
   Begin Date (Month/Year): ________ Completion Date (Month/Year): ________ Graduate Degree: ________

Continued on next page

8. Residency Training in Radiology:

Institution Name: ____________________

City: ____________ State or Province: ____________ Country: ____________

Program Director's Full Name: ____________________

Begin Date (Month/Year): ____________ Completion Date of Residency: ____________

9. Fellowship:

Institution Name: ____________________

City: ____________ State or Province: ____________ Country: ____________

Program Director's Full Name: ____________________

Begin Date (Month/Year): ____________ Completion Date of Fellowship: ____________

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

- Breast Imaging and Interventional
- Cardiac Radiology
- Chest Radiology
- Computed Tomography
- Diagnostic Radiology
- Education
- Emergency Radiology
- Gastrointestinal Radiology
- Genitourinary Radiology
- Head & Neck
- Health Policy
- Informatics
- Interventional
- Leadership & Management
- Magnetic Resonance Imaging
- Molecular Imaging
- Musculoskeletal Radiology
- Neuroradiology
- Nuclear Medicine
- OB/GYN
- Oncologic Imaging
- Pediatric Radiology
- Physics & Basic Science
- Professionalism (including Ethics)
- Radiation Oncology
- Research & Statistical Methods
- Safety & Quality
- Ultrasound
- Vascular
- Other

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 termination of the membership.

Signature of Applicant ____________________ Date ____________

RSNA CHARGE AUTHORIZATION FORM

Rates good through December 31

Annual Membership Dues — $50

Total Amount ____________________

Card Number ____________________ CVV ______

- VISA
- MasterCard
- Amex
- Discover
- Diners Club

Month ____ Year ____
Expiration Date

Bank Wire Transfer Information:
J.P. Morgan Chase Account Number 4184254; ABA: 071000013; SWIFT: CHASUS33; Fee $30

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., Suite 200
Oak Brook, IL 60523-2251

Phone: 1-877-RSNA-MEM, outside of U.S. & Canada 1-630-571-7873
Fax: 1-630-571-2198
E-mail: *membership@rsna.org*