RSNA®
Radiological Society of North America

MEMBERSHIP APPLICATION
(DISCOUNTED MEMBERSHIP DUES OPTION)

PLEASE TYPE OR PRINT:

1. Personal Information:

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

Academic Degrees to be published _____ Birthdate (Month/Day/Year) _____ / _____ / _____ ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer

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

Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic, Latino, or of Spanish Origin
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer Not to Answer

2. Specialty: _____
(i.e., diagnostic radiology, radiation oncology, medical physics)

Please Select One: ☐ Academic Setting ☐ Private Practice ☐ Other

Address Type ☐ Home ☐ Office

3. Address: (If you indicate an office address, please provide the institution name and department)

Institution Name/Department _____

Address _____

City _____ State or Province _____ ZIP/Postal Code _____ Country _____

4. Contact Information:

Home Phone _____ Email Address _____

Office Phone _____ Ext. _____ Cell Phone _____

Fax _____

5. If you are board certified, please specify:
Board _____ Year _____
(ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexican de Radiologia e Imagen, FRCR, JBRE, other)

6. Medical Education/University:

Medical/University School Name _____

Begin Date (Month/Year) _____ / _____ Completion Date (Month/Year) _____ / _____

7. Graduate Education: (Master or Doctorate Degree - *if applicable)*

Graduate School Name _____

Begin Date (Month/Year) _____ / _____ Completion Date (Month/Year) _____ / _____

8. Residency Training in Radiology:

Institution Name

City | State or Province | Country

Program Director's Full Name

Begin Date (Month/Year) | Completion Date (Month/Year)

9. Fellowship:

Institution Name

City | State or Province | Country

Program Director's Full Name

Begin Date (Month/Year) | Completion Date (Month/Year)

10. Profession Specialty, Primary Specialty, and Areas of Interest

Profession Specialty *(choose one)*

○Diagnostic Radiology ○Interventional Radiology ○Radiation Oncology ○Medical Sciences ○Nuclear Medicine ○Other

Mark one circle to indicate primary specialty. Mark all applicable squares for areas of interest

○☐ 3D Printing
☐ Artificial Intelligence
☐ Biomarkers/Quantitative Imaging
○☐ Breast (Imaging & Interventional)
○☐ Cardiac Radiology
○☐ Chest Radiology
☐ Computed Tomography
☐ Education
○☐ Emergency Radiology
☐ Fluroscopy
○☐ Gastrointestinal Radiology
○☐ Genitourinary Radiology
○☐ Head & Neck
☐ Health Policy
☐ Informatics
☐ Interventional Radiology
☐ 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
○ Not Applicable

11. 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

RSNA Charge Authorization Form

Rates valid through December 31, 2022

Annual Membership Dues: $50

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

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

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

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

AUTOMATIC MEMBERSHIP RENEWAL

☐ Yes, automatically renew my membership dues payment beginning in 2023

Total Amount | Expiration Date (Month/Year) | CVV

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