

PLEASE TYPE OR PRINT:

▶ Please complete all sections up to your level of training.

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)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> 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

Address Type Home Office

2. 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

3. Contact Information:

Email Address

Phone Number

4. Medical Education/University:

Medical/University School Name

_____/_____
Begin Date (Month/Year)

_____/_____
Completion Date (Month/Year)

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

Graduate School Name

_____/_____
Begin Date (Month/Year)

_____/_____
Completion Date (Month/Year)

6. 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

X _____
Dean of Medical School Signature

Date

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. Current Position: (choose one)

Medical Student FREE*

Qualifications

- Be enrolled in a medical school approved by the Liaison Committee for Medical Education or its equivalent.

Member-in-Training / Residents & Fellows FREE*

Qualifications

- Physicians in an approved radiology, radiation oncology, or nuclear medicine residency training program or subspecialty fellowship.

Graduate Student FREE*

Qualifications

- Be enrolled in an approved radiologic scientist or physics graduate school training program or subspecialty fellowship.

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

9. If you are board certified, please specify:

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

10. Fellowship:

Institution Name _____		Program Director's Full Name _____
City _____	State or Province _____	Country _____
Begin Date (Month/Year) _____ / _____	Anticipated Completion Date of Fellowship (Month/Year) _____ / _____	

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

X _____
Director of Current Residency/Fellowship Program Signature

Date

MEMBER BENEFITS

RSNA membership is free for medical students, graduate students and residents and fellows. You get over \$1,800 worth of value for free when you join RSNA.

YOU'LL GET:

Variety of trainee, online and in-person education

- Trainee resources: Physics Modules, Core Exam prep, Resident and Fellow Symposium
- Online: Hundreds of opportunities to earn CME and SA-CME
- In-person: Discounted webinars, Spotlight Courses and workshops

Career advancing grant opportunities

- Critical grant funding: The RSNA Research & Education (R&E) Foundation invests in the future of radiology by developing investigators and supporting lifelong innovative research and education
- Advancing radiologic science: Since the R&E Foundation's inception in 1984, it has awarded over \$70 million in grant funding to support more than 1,600 investigators

- Investing in radiology's future: In 2022, the R&E Foundation's Board of Trustees approved funding of over \$4 million in grants, achieving a funding rate of 42% of grant applications

Support to build your career and CV

- Microvolunteering opportunities
- Networking
- Volunteerism
- RSNA Case Collection
- Practice tools

Online subscriptions to industry-leading journals

- *RadioGraphics*
- *Radiology*
- *Radiology: Artificial Intelligence*
- *Radiology: Cardiothoracic Imaging*
- *Radiology: Imaging Cancer*

RSNA Charge Authorization Form

All Members:

- Add 3D Printing Special Interest Group for \$40

Rates valid through December 31, 2023

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

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.*