

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) _____ ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer
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 ☐ Interventional Radiology

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

Qualifications

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

Member-in-Training / Residents & Fellows

Qualifications

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

Graduate Student

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, AOCR, FRCP®, Consejo Mexican 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

2026 TRAINEE MEMBERSHIP BENEFITS		STANDARD \$0
Year-Round Benefits	Online subscriptions to all six RSNA peer-reviewed journals and two legacy collections Includes <i>RadioGraphics</i> Core Exam Prep	✓
	Free registration to all RSNA webinars	✓
	Discounted registration to RSNA Spotlight Courses	✓
	Unlimited access to RSNA EdCentral	✓
	Complimentary access to CME activities and high-quality education in all subspecialties, including Physics Modules	✓
	Comprehensive access to RSNA Case Collection™	✓
	Access to career support, grant and volunteer opportunities	✓
Annual Meeting Benefits	Discounted 2026 RSNA annual meeting registration Bonus: In-person member registration includes virtual access! — OR —	\$100* — OR —
	Virtual Only registration to the 2026 RSNA annual meeting	\$100*

*Price valid through Oct. 1

RSNA Charge Authorization Form

All Members:

- ☐ Add 3D Printing Special Interest Group for \$40
☐ Add Donation to the R&E Foundation (Suggested Donation of \$50)

Rates valid through December 31, 2026

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
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