RSNA®
Radiological Society of North America

EDUCATION MATERIALS AND JOURNAL AWARD PROGRAM SUBSCRIPTION RENEWAL FORM

PLEASE TYPE OR PRINT. IF COMPLETING THIS ELECTRONICALLY, USE ADOBE READER, AVAILABLE FREE ONLINE.

▸ Only applicants representing radiology teaching institutions, hospitals, or medical libraries from developing countries are eligible for this program.

1. Date of Renewal Request:

_______ / _______ / _______
(Month/Day/Year)

2. Name and Department of Teaching Institution/Hospital/Medical Library:

Name ______________________ Department ______________________

3. Name of Department Chairman or Director:

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

4. Is the institution a non-for-profit organization? ☐ Yes ☐ No

5. Institution Website, if Available:
If a web address is not available, please submit a copy of an informational brochure from your institution or a brief overview of your facility along with your completed application.

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6. Request for Journal Subscription

	Electronic, Online Access (strongly encouraged)	Print Copy, Mailed
Radiology Subscription	☐	☐
RadioGraphics Subscription	☐	☐

7. Delivery of Education:
Please provide the information below, based on the education requested in question #6.

If you are requesting an online subscription to *Radiology* and/or *RadioGraphics* for the first time, or the IP address(es) provided in your original application have changed, please provide the IP address(es) of your institution that should be granted access
(Note: a limited number of IP addresses can be accommodated.)

1. ______ 2. ______ 3. ______

If you are requesting a print subscription to *Radiology* and/or *RadioGraphics*:

Recipient's Name ______________________

Address ______________________

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

8. If your institution has previously received hard-copies of the RSNA journal, did you receive the journals in a timely manner? ☐ Yes ☐ No

9. List the major educational needs of your program/institution, in order of priority.

1. ______ 2. ______ 3. ______

4. ______ 5. ______ 6. ______

10. Type of procedures performed (check all that apply).

☐ Breast/Mammography	☐ Diagnostic Radiology	☐ Interventional	☐ Nuclear Medicine
☐ Cardiovascular	☐ Gastrointestinal	☐ Magnetic Resonance	☐ Pediatric Radiology
☐ Chest	☐ Genitourinary	☐ Musculoskeletal	☐ Radiation Oncology
☐ CT	☐ Head & Neck	☐ Neuroradiology	☐ Ultrasound

11. Indicate the number of faculty and residents that have access to *Radiology* and/or and *RadioGraphics* through your current subscription.

Faculty

Residents

12. Describe how access to education through your *Radiology* and/or *RadioGraphics* subscription has impacted the faculty and residents at your institution. Please provide specific examples.

Faculty

Residents

13. Please provide any other information that would be helpful for the review committee.

Submit your completed application to *CIRE@rsna.org* or send via mail to the address below.

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