RSNA®
Radiological Society of North America

MEMBER-IN-TRAINING AND MEDICAL STUDENT MEMBERSHIP APPLICATION

PLEASE TYPE OR PRINT:

- **Medical Students:** Please complete lines 1 through 5.
- **Residents/Fellows:** Please complete lines 1 through 4, 6 (*if applicable*) and 7 through 10.
- **Radiologic Scientist Students:** Please complete lines 1 through 3, 6, 9 (*if applicable*) and 10.

1. Personal Information:

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

Academic Degrees/Credentials to be published, 2 maximum

_____ / _____ / _____ Birthdate (Month/Day/Year) ☐ Male ☐ Female

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

Where do you prefer to receive your journals and correspondence? ☐ 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:

Primary Phone | Preferred Email

Office Phone

4. Medical Education/University:

Medical School/University Name | Degree/Medical Degree

City | State or Province | Country

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

5. 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

Medical Student FREE*
- Add North American print journals for $80
- Add international journals for $170

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

Member-in-Training / Residents & Fellows FREE*
- Add North American print journals for $80
- Add international journals for $170

Qualifications
- Physicians in an approved residency training program or subspecialty fellowship
- Radiologic scientist students in an approved training program or subspecialty fellowship

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

6. Graduate Education: (i.e., Master or Doctorate Degree) - *If applicable*

Graduate School Name

Graduate Degree

City | State or Province | Country | Begin Date (Month/Year) | Completion Date (Month/Year)

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. If you are board certified, please specify: Board _____ Year _____

(ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexican de Radiologia e Imagen, FRCR, JBRE, other)

9. Fellowship:

Institution Name

Program Director's Full Name

City | State or Province | Country

Begin Date (Month/Year)

Anticipated Completion Date of Fellowship (Month/Year)

10. 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

RSNA Charge Authorization Form

Select One (Optional) Print Journal Category: *See reverse side for category qualification*

☐ North America $80
☐ International $170

Rates valid through December 31, 2018

All Members:

☐ Add 3D Printing Special Interest Group for $40

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.
Oak Brook, IL 60523-2251

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

MEM623 TD