The Radiological Society of North America (RSNA) is a professional membership organization devoted to developing the highest standards of radiology and related sciences through education and research. Members are radiologists, radiation oncologists, medical physicists, nuclear medicine physicians, radiologic scientists, dentists, physicians (non-radiologists) and veterinarians.

Online subscriptions

RadioGraphics
The journal of continuing medical education in radiology

Radiology
The most clinically relevant, highest-quality science in radiology

RSNA News
Up-to-date news about radiologic research, education and RSNA programs

Highest-quality education resources

RSNA members have access to the most current, peer-reviewed education materials in radiology to help them remain at the top of their field.

Free opportunities for CME credit

Learn about RSNA Research and Education Foundation grants and eligibility requirements.

Find information at RSNA.org/Grants-and-Awards.

Find out how RSNA is helping more than 54,000 of your colleagues maintain their professional edge.

Join today. Apply online at RSNA.org/Apply.

Please follow the instructions for application appearing on the next page.
The Radiological Society of North America (RSNA) is pleased to offer reduced membership dues to eligible members or applicants in certain areas of the world, allowing easy access to training and education in radiology. Membership is at the reduced rate of $50.00.

Your membership benefits will include online access to all areas of the RSNA website, including the RSNA online journals *Radiology* and *RadioGraphics* and our monthly newsletter—*RSNA News*. This reduced membership fee does not include RSNA annual meeting registration.

Membership cycle runs January 1-December 31. Dues rates good through December 31.

Online journal access is an RSNA benefit provided free to members. By signing this application, you agree to protect this benefit from misuse by accessing the journals for your personal use only. Please safeguard your user name and password.

### Instructions for Application

- Fill in required information.
- Sign line 12.
- Forward your completed application, dues payment and updated curriculum vitae to RSNA at the address below.
- Or apply online at [RSNA.org/Apply](http://RSNA.org/Apply).

### Procedure for Admission

1. Once received, your application will be reviewed by RSNA.
2. New applicants’ names will be published online for review by members.
3. You will be notified in 6–8 weeks about your membership status.
Membership Application
(Discounted Membership Dues Option)

Please type or print

1. First Name: ___________________________________________ Middle Name: _________________________________

Last Name (Family name): _________________________________________________________________________

Academic Degrees/Credentials to be published (Max. of 2): ______________________________________________

Birthdate (Month/Day/Year): _______ ☑ Male ☑ Female

Spouse/Domestic Partner’s Name: __________________________________________ Prefix (Dr., Prof., Mr., Mrs., Ms.): ___

Specialty: _____________________________________________ ☑ Academic Setting ☑ Private Practice ☑ Other

2. (i.e., Diagnostic Radiology, Radiation Oncology, Medical Physics)

Primary Activity: ☑ Basic Research ☑ Clinical ☑ Teaching (Please Select One)

3. Where do you prefer to receive your correspondence? ☑ Home ☑ Office

4. Address:

(If you indicate an office address, be sure to provide the institution name and department)

_______________________________________________________________________________________________

_______________________________________________________________________________________________

City: ___________________________ State or Province: ___________ ZIP/Postal Code: _______________

Country: _______________________________________________________________________________________

5. Contact Information:

Home Phone: ______________________ E-mail: ______________________

Office Phone: ____________________ Ext. ___ Cell Phone: _______________ Fax: _______________________

6. If you are board certified, please specify:

Board: ___________________________________________________________________________ Year: _____________

(ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexicano de Radiología e Imagen, FCR, JBR, other)

7. Medical Education/University:

Medical School Name: __________________________________________________________________________

City: ___________________________ State or Province: ___________ Country: _______________

Begin Date (Month/Year): ________ Completion Date (Month/Year): ________ Degree/Medical Degree: ______

8. Graduate Education (i.e., Master or Doctorate Degree):

Graduate School Name: __________________________________________________________________________

City: ___________________________ State or Province: ___________ Country: _______________

Begin Date (Month/Year): ________ Completion Date (Month/Year): ________ Graduate Degree: __________

________________________________________________________

Continued on next page
9. Residency Training in Radiology:

Institution Name: ________________________________________________________________
City: ___________________________ State or Province: ____________ Country: ________________
Program Director’s Full Name: ____________________________________________________
Begin Date (Month/Year): ______________________ Completion Date of Residency: ________________

10. Fellowship:

Institution Name: ________________________________________________________________
City: ___________________________ State or Province: ____________ Country: ________________
Program Director’s Full Name: ____________________________________________________
Begin Date (Month/Year): ______________________ Completion Date of Fellowship: ________________

11. Subspecialty Areas of Interest: Mark one circle to indicate primary specialty. Mark all applicable squares for areas of interest.

- Breast Radiology
- Computed Tomography
- Education
- Genitourinary Radiology
- Informatics
- Magnetic Resonance Imaging
- Neuroradiology
- Oncologic Imaging
- Professionalism
- Research & Statistical Methods
- Vascular
- Cardiac Radiology
- Diagnostic Radiology
- Emergency Radiology
- Head & Neck
- Interventional
- Molecular Imaging
- Nuclear Medicine
- Pediatric Radiology
- Radiation Oncology
- Safety & Quality
- Other
- Chest Radiology
- Digital Mammography
- Gastrointestinal Radiology
- Health Policy & Practice
- Leadership & Management
- Musculoskeletal Radiology
- OB/GYN
- Physics & Basic Science
- Radiobiology
- Ultrasound

12. I agree to abide by the current bylaws and any revisions 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.

_________________________________________  ____________________________
Signature of Applicant             Date

RSNA CHARGE AUTHORIZATION FORM

Rates good through December 31
Annual Membership Dues —$50.00

Total Amount ________________________________________________

Card Number

Bank Wire Transfer Information:
J.P. Morgan Chase Account Number 4184254; ABA: 071000013; SWIFT: CHASUS33; Fee $30.00

Signature ____________________________________________

Name as it appears on card

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
Phone: 1-877-RSNA-MEM, outside of U.S. & Canada 1-630-571-7873
Fax: 1-630-571-2198
E-mail: membership@rsna.org

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