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, be sure to provide the institution name and department)

Institution Name/Department _____

Address _____

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

3. Contact Information:

Home Phone _____ Preferred Email _____

Cell Phone _____ Fax Number _____

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 print journals for $80

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

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

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

International Member-in-Training / Residents & Fellows FREE*
Add print 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

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RSNA Charge Authorization Form

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

☐ Medical Student $80
☐ Resident/Fellow North America $80
☐ Resident/Fellow International $170

Rates valid through December 31, 2016

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)

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

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