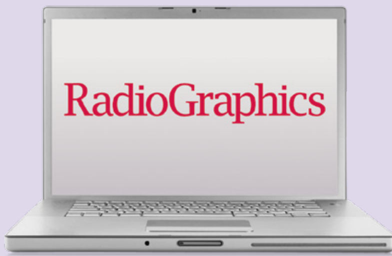
RSNA®
Radiological Society of North America

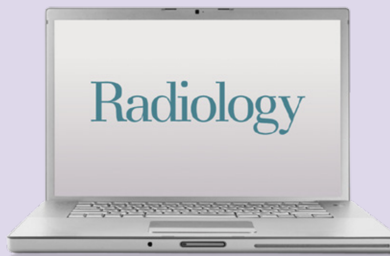
Membership Application
(Discounted Membership Dues Option)

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



The journal of continuing medical education in radiology



The most clinically relevant, highest-quality science in radiology

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.

› *Education.RSNA.org*

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.

Annual Membership Dues

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.

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 to 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*.

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 to 8 weeks about your membership status.

☐ Approved ☐ Disapproved

RCVD ____________ ACKN ____________

Rec Date: ACCTG ________ DM ______ MBR ______

RTG ____________ ADM (Mo/Day/Year) ________

Member Number ____________________

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/Life Partner's Name: ______________________ Prefix (Dr., Prof., Mr., Mrs., Ms.):_____
   First Name Last (Family) Name

2. **Specialty:** ______________________ ☐ Academic Setting ☐ Private Practice ☐ Other
   (i.e., Diagnostic Radiology, Radiation Oncology, Medical Physics) (Please Select One)

   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: ____________________ Email: ____________________

   Office Phone: __________ Ext. ___ Cell Phone: __________ Fax: __________

6. **If you are board certified, please specify:**

   Board: __________________________________ Year: __________
   (ABR, ABMP, ABNM, AOCR, FRCP©, Consejo Mexicano de Radiologia e Imagen, FRCR, 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 Imaging and Interventional
- Cardiac Radiology
- Chest Radiology
- Computed Tomography
- Diagnostic Radiology
- Education
- Emergency Radiology
- Gastrointestinal Radiology
- Genitourinary Radiology
- Head & Neck
- Health Policy
- Informatics
- Interventional
- Leadership & Management
- Magnetic Resonance Imaging
- Molecular Imaging
- Musculoskeletal Radiology
- Neuroradiology
- Nuclear Medicine
- OB/GYN
- Oncologic Imaging
- Pediatric Radiology
- Physics & Basic Science
- Professionalism (including Ethics)
- Radiation Oncology
- Research & Statistical Methods
- Safety & Quality
- Ultrasound
- Vascular
- Other

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 termination of the membership.

______________________________ Signature of Applicant

______________ Date

RSNA CHARGE AUTHORIZATION FORM

Rates good through December 31

Annual Membership Dues — $50

______________________________ Total Amount

______________________________ Card Number

________ CVV

- VISA
- MasterCard
- Amex
- Discover
- Diners Club

Month ____ Year ____ Expiration Date

Bank Wire Transfer Information:
J.P. Morgan Chase Account Number 4184254; ABA: 071000013; SWIFT: CHASUS33; Fee $30

______________________________ 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*