

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



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A personal homepage to store files, bookmarks and searches, accessible from any computer

Find out how RSNA is helping more than 51,000 of your colleagues maintain their professional edge.

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

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 \$50.00.

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, 2013

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 11.
- 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 6–8 weeks about your membership status.



Membership Application (Discounted Membership Dues Option)

Please type or print

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.): _____
First Name Last (Family) Name

Specialty: _____ Academic Setting Private Practice Other

1. (i.e., Diagnostic Radiology, Radiation Oncology, Medical Physics) (Please Select One)

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

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

3. Address:

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

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

Country: _____

4. Contact Information:

Home Phone: _____ E-mail: _____

Office Phone: _____ Ext. ____ Cell Phone: _____ Fax: _____

5. If you are board certified, please specify:

Board: _____ Year: _____
(ABR, ABMP, ABNM, AOCR, FRCP®, Consejo Mexicano de Radiologia e Imagen, FRCR, JBR, other)

6. Medical Education/University:

Medical School Name: _____

City: _____ State or Province: _____ Country: _____

Begin Date (Month/Year): _____ Completion Date (Month/Year): _____ Medical Degree: _____

7. 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: _____

Approved Disapproved
RCVD _____ ACKN _____
Rec Date: ACCTG _____ DM _____ MBR _____
RTG _____ ADM (Mo/Day/Year) _____
Member Number _____

8. Residency Training in Radiology:

Institution Name: _____
City: _____ State or Province: _____ Country: _____
Program Director's Full Name: _____
Begin Date (Month/Year): _____ Completion Date of Residency: _____

9. Fellowship:

Institution Name: _____
City: _____ State or Province: _____ Country: _____
Program Director's Full Name: _____
Begin Date (Month/Year): _____ Completion Date of Fellowship: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Breast/Mammography | <input type="checkbox"/> <input type="checkbox"/> Cardiac Radiology | <input type="checkbox"/> <input type="checkbox"/> Chest |
| <input type="checkbox"/> <input type="checkbox"/> Computed Tomography | <input type="checkbox"/> <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> <input type="checkbox"/> Emergency Radiology |
| <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> <input type="checkbox"/> Genitourinary | <input type="checkbox"/> <input type="checkbox"/> Head & Neck |
| <input type="checkbox"/> <input type="checkbox"/> Health Policy & Practice | <input type="checkbox"/> <input type="checkbox"/> Informatics | <input type="checkbox"/> <input type="checkbox"/> Interventional |
| <input type="checkbox"/> <input type="checkbox"/> Magnetic Resonance | <input type="checkbox"/> <input type="checkbox"/> Molecular Imaging | <input type="checkbox"/> <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> <input type="checkbox"/> Neuroradiology | <input type="checkbox"/> <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> <input type="checkbox"/> Oncologic Imaging | <input type="checkbox"/> <input type="checkbox"/> Pediatric Radiology | <input type="checkbox"/> <input type="checkbox"/> Physics |
| <input type="checkbox"/> <input type="checkbox"/> Professionalism | <input type="checkbox"/> <input type="checkbox"/> Quality Assurance | <input type="checkbox"/> <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> <input type="checkbox"/> Radiobiology | <input type="checkbox"/> <input type="checkbox"/> Research | <input type="checkbox"/> <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> <input type="checkbox"/> Vascular | <input type="checkbox"/> <input type="checkbox"/> Other | |

11. 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, 2013

Annual Membership Dues —\$50.00

Total Amount

Card Number

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> VISA | <input type="checkbox"/> Discover |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Diners Club |
| <input type="checkbox"/> AMEX | |

_____/_____/_____
Month Year

Bank Wire Transfer Information:

J.P. Morgan Chase Account Number 4184254; ABA: 071000013; SWIFT: CHASUS33; Fee \$30.00

Expiration Date

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