RSNA®
Radiological Society of North America

EDUCATION MATERIALS AND JOURNAL AWARD PROGRAM APPLICATION FORM

PLEASE TYPE OR PRINT. IF COMPLETING THIS ELECTRONICALLY, USE ADOBE READER, AVAILABLE FREE ONLINE.

▸ Only applicants representing radiology teaching institutions, hospitals or medical libraries from developing countries are eligible for this program.

1. Application Date:

_____ / _____ / _____
(Month/Day/Year)

2. Name and Department of Teaching Institution/Hospital/Medical Library:

Name _____ Department _____

3. Name of Department Chairman or Director:

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

4. Is the institution a non-for-profit organization? ☐ Yes ☐ No

5. Institution Website, if Available:
If a web address is not available, please submit a copy of an informational brochure from your institution or a brief overview of your facility along with your completed application.

_____

6. Request for Education

RSNA Journals:

	Electronic, Online Access (strongly encouraged)	Print Copy, Mailed
Radiology Subscription	☐	☐
RadioGraphics Subscription	☐	☐

Educational Materials:
Click here (*rsna.org/purchase*) to review available materials from the RSNA Education Resources Catalog.

List your requested materials in the space provided below. Note: Materials are only available in a USB/flash drive format.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. Delivery of Education:
Please provide the information below, based on the education requested in question #6.

If you are requesting an online subscription to *Radiology* and/or *RadioGraphics*, provide the IP address(es) of your institution that should be granted access. This information is required.

(Note: a limited number of IP addresses can be accommodated.)

1. _____ 2. _____ 3. _____

If you are requesting a print subscription to *Radiology* and/or *RadioGraphics* or education from the RSNA Education Resources Catalog:

Recipient's Name _____

Address _____

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

8. Briefly describe the radiology training program, if applicable:

Length of training

Content of training

Number of trainees

Language(s) in which medicine is taught:

9. List the major educational needs of your program/institution, in order of priority.

1. 2. 3.

4. 5. 6.

10. Type of procedures performed (check all that apply).

- ☐ Breast/Mammography
- ☐ Cardiovascular
- ☐ Chest
- ☐ CT
- ☐ Diagnostic Radiology
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Head & Neck
- ☐ Interventional
- ☐ Magnetic Resonance
- ☐ Musculoskeletal
- ☐ Neuroradiology
- ☐ Nuclear Medicine
- ☐ Pediatric Radiology
- ☐ Radiation Oncology
- ☐ Ultrasound

11. If your application is approved, please indicate the number of faculty and residents that will have access to the requested education.

Faculty Residents

12. How do you intend to use the requested education?

13. Please provide any other information that would be helpful for the review committee.

Submit your completed application to *CIRE@rsna.org* or send via mail to the address below.

Radiological Society of North America
ATTN: Department of International Affairs
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