ARRS
Your Medical Imaging Society
CONNECT • LEARN • ADVANCE

Membership Application

For ARRS office use:

Date Received_____

ID#_____

A. SELECT YOUR MEMBERSHIP TYPE

Members are eligible to participate in all ARRS activities including holding elective office and voting privileges.

☐ Member

Individuals in the practice of radiology, radiation oncology or nuclear medicine who are medical school graduates that have completed a radiology residency program.

*Online Only *(all countries)*

1 year	2 years	3 years—*Best Value!*
☐ $350	☐ $675	☐ $975

Print and Online *(located in North America, including United States territories)*

1 year	2 years	3 years—*Best Value!*
☐ $395	☐ $765	☐ $1,110

Print and Online *(located outside North America)*

1 year	2 years	3 years—*Best Value!*
☐ $490	☐ $955	☐ $1,395

* Members selecting Online Only membership will not receive the print journal *AJR*. Online Only members will have access to the publication online.

Note: If you are a medical student, resident, or fellow, please complete the application for membership located at ***www.arrs.org/In-TrainingApp***

☐ Associate Member

Individuals in the practice of radiology-related sciences and allied health professionals.

*Online Only *(all countries)*

1 year	2 years	3 years—*Best Value!*
☐ $350	☐ $675	☐ $975

Print and Online *(located in North America, including United States territories)*

1 year	2 years	3 years—*Best Value!*
☐ $395	☐ $765	☐ $1,110

Print and Online *(located outside North America)*

1 year	2 years	3 years—*Best Value!*
☐ $490	☐ $955	☐ $1,395

Please indicate the type of associate member you are, based on your profession:

- ☐ Nurse
- ☐ Physicist
- ☐ Radiology Administrator
- ☐ Radiology Assistant
- ☐ Radiologic Technologist
- ☐ Radiology Business Manager
- ☐ Radiology Practitioner
- ☐ Physician (non-Radiologist)

_____
(please specify type of physician)

B. CONTACT AND DEMOGRAPHIC INFORMATION

Date of Birth (Month/Date/Year):_____ Gender: ☐ Male ☐ Female

Name (please print): _____
Last First Initial Degree(s)

Home Address: _____
Street Address or Post Office Box

_____
City State/Province Zip/Postal Code Country

Home Phone:_____ Fax:_____ Email (home):_____

Employer Address:_____
Organization Street Address or Post Office Box

_____
City State/Province Zip/Postal Code Country

Work Phone:_____ Fax:_____ Email (work):_____

Please indicate where you prefer to receive print member correspondence: ☐ Home ☐ Work

Please indicate where you prefer to receive email member correspondence: ☐ Home ☐ Work

☐ Occasionally, ARRS rents mailing lists to companies with radiology-related products and services. If you prefer to exclude your name from mailing lists rented by ARRS, please check here.

C. PROFESSIONAL INFORMATION

Members are eligible to participate in all ARRS activities including holding elective office and voting privileges.

PRACTICE TYPE:

☐ Government ☐ Military ☐ University ☐ Academic/Research/Faculty
☐ Hospital ☐ Private Practice ☐ Other (specify): _____

PRIMARY AREA OF PRACTICE AND/OR INTEREST:

☐ Abdominal Imaging ☐ Emergency Radiology ☐ Musculoskeletal Imaging ☐ Radiation Oncology
☐ Breast Imaging ☐ Gastrointestinal Imaging ☐ Neuroradiology ☐ Ultrasound
☐ Cardiac Imaging ☐ Genitourinary Imaging ☐ Nuclear Medicine ☐ Vascular/Interventional
☐ Chest/Pulmonary Imaging ☐ Mammography ☐ Pediatric Imaging ☐ Women's Imaging
☐ Other (specify): _____

EDUCATION INFORMATION

Graduate (Medical School, Graduate School, etc.): _____

_____

Postgraduate (Internships, Residencies, Fellowships, etc.): _____

_____

CERTIFICATION INFORMATION

Are you board certified? ☐ Yes ☐ No If **yes**, please complete the following:

I hereby certify that I am certified by the _____ (Name of Qualifying Board) in _____ (Specialty (i.e. radiology)).

My certification began in _____ (Year you became certified) and I am subject to re-certification in _____ (Year you must recertify, if applicable).

Do you have a Subspecialty Certification from the American Board of Radiology? ☐ Yes ☐ No

If **yes**, please indicate the area:

☐ Interventional Radiology/Diagnostic Radiology ☐ Nuclear Radiology ☐ Vascular/Interventional Radiology
☐ Neuroradiology ☐ Pediatric Radiology

VOLUNTEER OPPORTUNITIES

Members are encouraged to get involved with ARRS. Volunteer opportunities are available at **www.arrs.org/volunteeropportunities**.

D. PAYMENT INFORMATION

Dues Amount: _____
Nonrefundable Application Processing Fee: **$50.00**
Total: _____

Payment Options:

☐ Visa ☐ American Express
☐ MasterCard ☐ Check (Payable to the ARRS in U.S. funds)

Card No: _____

Expires: ____ ____

Send completed form to:

ARRS
Attn: Member Services
44211 Slatestone Court
Leesburg, VA 20176-5109 U.S.A.

Toll-free: (866) 940-2777 (U.S. and Canada)
Phone: (703) 729-3353
Fax: (703) 729-4839
Email: membership@arrs.org

Apply online at: www.arrs.org

Membership is effective upon processing of completed application and activation of account. Please allow 2–4 weeks for processing. Of the annual dues amount, $70.00 is allocated for a subscription to the *AJR*; $5.00 is allocated for a subscription to ARRS *InPractice*.

In submitting this ARRS membership application, I agree and understand the $50.00 application processing fee is **nonrefundable**.

E. AUTHORIZING SIGNATURE

Sign below indicating that all the information you have provided in this application is correct to the best of your knowledge and to authorize payment as you have indicated above.

Applicant's Signature for Payment: _____ Today's Date: _____