ARRS
Your Medical Imaging Society
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# In-Training Membership Application

*For ARRS office use:*

Date Received_____

ID#_____

WEB19

## A. SELECT AND VERIFY YOUR MEMBERSHIP TYPE

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

### In-Training Member

Residents or fellows in radiology, interventional radiology/diagnostic radiology, radiation oncology or nuclear medicine program, a student in a medical school program or radiology-related science or allied science program. Training status must be verified by a program director or chair.

***Online Only** *(all countries)*

☐ $0 per year

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

☐ $95 per year

**Print and Online** *(located outside North America)*

☐ $175 per year

*In-training members selecting online only will not receive a print journal. In-training members may only select print and online if they are in training for more than 6 months after date of application.

I certify that I am a ☐ resident ☐ fellow ☐ medical student_____
Specialty

at_____
Name of Institution

Date program began/begins:_____ (Month/Date/Year) Date program ends:_____ (Month/Date/Year)

**Verification:** (Program Director or Department Chair only)

*I certify that this applicant is a resident, fellow or medical student at the above-named institution.*

Name (Please print):_____

Address:_____

Phone:_____ Email:_____

Signature:_____

## B. CONTACT AND DEMOGRAPHIC INFORMATION

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

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

Home Address: _____
Street Address

_____
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** (Indicate name of medical school and year of graduation.): _____

_____

**Postgraduate** (Indicate location of Residency with begin and end dates of program. If applicable, indicate location of Fellowship with begin and end dates of program. Also indicate fellowship specialty area.): _____

_____

**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. diagnostic 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 (if adding print journal to your free membership): _____

**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.

## D. AUTHORIZING SIGNATURE

Sign below to indicate the information you have provided 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: _____