



Application for Medical School Student or Transitional Year Resident for Member-in-training Membership

I am a: Medical Student Transitional Year Resident

I am very interested in becoming a (check one):

- Diagnostic Radiologist Interventional Radiologist Radiation Oncologist Nuclear Medicine Physician
 Medical Physicist

Please Note: Your membership application will not be accepted unless it is accompanied by a letter on school stationery from your program verifying your current training status and including the starting and ending dates of your current training.

Please print or type.

Applicant's Name in Full: _____ Degrees: _____
Last First Middle (M.D., Ph.D., M.B., etc.)

Former Name (if applicable): _____ E-mail Address: _____

Gender M F Birth Date* _____ Last 4 digits of SSN/SIN* _____

Home Address: _____ Business Address: _____

City _____ City _____

State/Province _____ ZIP/Postal Code _____ State/Province _____ ZIP/Postal Code _____

Country _____ Country _____

Home address will be used for mailings.

Preferred Billing Address: Home Business

Business information will be used for Membership Directory, per ACR Council 1987 resolution, amended 1997, 2007 (Res. 36-A).

Home Phone _____ Business Phone _____

Home Fax _____ Business Fax _____

**Mail application and letter on school stationery from medical school or
transitional year residency program verifying your status and dates of training to:**

Membership Services • American College of Radiology • 1891 Preston White Dr. • Reston, VA 20191-4397 • USA
00+1 703-648-8900, ext. 4064 • 00+1 800-347-7748 • Fax 00+1 703-264-2093 • E-mail membership@acr.org

*Birth date and last four digits of SSN/Canadian SIN are used to uniquely identify you in our database.