

# Application for International Membership

**I am a:**

Diagnostic radiologist  Interventional radiologist  Radiation oncologist  Nuclear medicine physician  Medical physicist

**I am applying to be an:**

**International Member**

By checking the box above, you are certifying that you are eligible to practice or certified to practice radiology/radiation oncology/medical physics outside the United States or Canada and therefore are eligible only to be an International Member of the American College of Radiology.

**Please print or type.**

Applicant's Name in Full \_\_\_\_\_ Degrees \_\_\_\_\_  
Last First Middle (MD, PhD, MB, etc.)

Former Name \_\_\_\_\_ Email Address \_\_\_\_\_

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 \_\_\_\_\_

Gender  M  F

Birth Date\* \_\_\_\_\_

**Order a Subscription to the JACR**

Check here to order a one-year print subscription to the *Journal of the American College of Radiology (JACR)* for \$85 USD.  
**Please enclose your payment of \$85 with your ACR membership dues.** (Online version of the JACR is included with the international membership dues.)

\*Birth date is used to uniquely identify you in our database.

**Disciplinary History** — If yes, please explain the circumstances and outcome in the area provided below.

YES NO

1.   Have you ever been convicted of a criminal offense in any country, pled "no contest" or "nolo contendere" or entered into a plea bargain regarding such offense?
2.   Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any medical school, residency or fellowship training, hospital, nursing home, health care facility or health care provider?
3.   Have you ever had any of the following disciplinary actions taken against your license to practice medicine? (Check all that apply.)
  - suspension/revocation
  - probation
  - reprimand/cease and desist
  - had your practice monitored
  - limitation placed on scheduled drugs
4.   Have you ever surrendered your medical license while under investigation or in lieu of investigation or disciplinary action?
5.   Have you ever had any membership in a professional society revoked, suspended or sanctioned?
6.   Have you voluntarily withdrawn from any professional society while under investigation or in lieu of disciplinary action?

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree to abide by the current bylaws, policies and procedures of the College and the Association and any future revisions thereof.

I herby certify that the information given above is correct to the best of my knowledge.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**Payment Information**

- Check payable to ACRA\*
- Credit Card  American Express (15 digits)
- MasterCard (16 digits)
- Visa (13 or 16 digits)

Credit Card No.	Expiration Date
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Cardholder's Name \_\_\_\_\_  
(please print)

Cardholder's Signature \_\_\_\_\_

**\*Enclose check payable to ACRA** to cover ACR dues (\$335 USD). Or fax application and pay by credit card.  
(We accept Visa, MasterCard, and American Express.) **Mail application and payment to:**

Membership Services • American College of Radiology • 1891 Preston White Dr. • Reston, VA 20191-4326 • USA  
00+1 703-648-8900, ext. 4064 • 00+1 800-347-7748 • Fax 00+1 703-264-2093 • Email [membership@acr.org](mailto:membership@acr.org)