



APPLICATION FOR ALLIED HEALTH MEMBERSHIP/
CHAPTER APPLICATION FOR MEMBERSHIP

I am a [] MRI Scientist
I am certified by: Certifying Body: Date Certified:
Other Certification: Certifying Body: Date Certified:
[] Radiologist Assistant
I received my Registered Radiologist Assistant (R.R.A.) certification from the ARRT on: Date:

(Please submit copies of notifications of certifications with application.)

NOTE: Applicants practicing in the US must also belong to a College chapter. Chapter membership is optional for active employees of the U.S. military services and the U.S.P.H.S. This application is also an application for chapter membership. Applicants practicing in Canada must belong to the Canadian Association of Radiologists. Call the CAR at (514) 738-3111 to join the CAR or to verify your CAR membership.

PLEASE PRINT OR TYPE

NAME DEGREES
Last First Middle (MD, PhD, MB, etc.)
FORMER NAME E-MAIL ADDRESS
HOME ADDRESS BUSINESS ADDRESS
City State/Province ZIP City State/Province ZIP
Country (if not U.S.) Country (if not U.S.)

Home address will be used for mailings. BILLING ADDRESS [] Home [] Business
Business information will be used for Membership Directory, per ACR Council 1987 resolution, amended 1997 (Res. 35-B).

HOME PHONE () BUSINESS PHONE ()
HOME FAX () BUSINESS FAX ()
GENDER [] M [] F BIRTH DATE* SOCIAL SECURITY #-LAST 4 DIGITS*
Check if employed fulltime by: [] Veterans Admin. [] USPHS [] Army [] Navy [] Air Force [] Marines

TRAINING Name of Institution Specialty Yr Grad
ADDITIONAL TRAINING Name of Institution Specialty Yr Grad

REQUIRED-TWO CHAPTER SPONSOR SIGNATURES**. You must join the chapter 1) where you conduct your principal practice, 2) where you reside or 3) located within 25 miles of either location. To join, please obtain the signatures of two people who are active members in good standing of the chapter for which you are applying.

1. SIGNATURE OF FIRST SPONSOR 2. SIGNATURE OF SECOND SPONSOR
1. LEGIBLY PRINTED NAME OF FIRST SPONSOR 2. LEGIBLY PRINTED NAME OF SECOND SPONSOR

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant Date

**Note: See enclosed Dues Schedule for chapters that do not require sponsors.

Enclose check payable to ACRA to cover both ACR/ACRA and chapter dues. Refer to enclosed Dues Schedule (In AR, CA, Canada, CO, CT, DE, FL, LA, NJ, PA, TN attach only ACRA payment—chapter will bill you separately). Mail application and payment to:

Membership Services • American College of Radiology • 1891 Preston White Dr. • Reston, VA 20191-4397

• (703) 648-8900, ext. 4064 • (800) 347-7748 • Fax (703) 264-2093 • E-mail membership@acr.org

*Birth date and social security numbers are used to uniquely identify you in our database.