Founded 1958
The Society for PEDIATRIC RADIOLOGY

The Society for Pediatric Radiology
1891 Preston White Drive
Reston, VA 20191
www.pedrad.org spr@acr.org

• MEMBERSHIP APPLICATION •

Request appropriate membership category by checking one below:

☐ ACTIVE membership is limited to Board certified radiologists with a significant interest in clinical, educational and research practice of pediatric radiology or pediatric radiology oncology who also have completed a minimum of one year of training in pediatric radiology above and beyond what is required by ordinary board Examination in Radiology or demonstrated competence in pediatric radiology considered by the Board of Directors to be equivalent to such additional training.

☐ ASSOCIATE membership is open to other radiologists, other physicians, or scientists residing in North America who are interested in the science of pediatric radiology, but who do not fully qualify for Active membership.

☐ CORRESPONDING membership is open to pediatric radiologists otherwise eligible for Active or Associate membership who work outside of the United States or Canada.

☐ MEMBER-IN-TRAINING status is offered to radiologists during their pediatric radiology fellowships. The Member-in-training shall be considered for election to Active status upon completion of fellowship training.

PLEASE COMPLETE: (type or print)

APPLICATION DATE: ____________________

1. ____
First Name MI Last Name Generation (Jr, Sr, III) Degree(s) (2 highest)

____
Gender (Male/Female) Date of Birth (mo/day/year)

2. Preferred mailing address/method (*for directory listing, correspondence, journal subscription*): ☐ Email only ☐ US Mail

a. ____
Department/mail code Institution Name Address

____
City State/province Zip+4/postal code Country (if not USA)

b. ____
Home address: street address, city, state/province, zip+4/postal code, Country (if not USA)

c. ____
Work phone Work fax Email address (IMPORTANT!)

____
Home phone Home fax Spouse name and degree (optional)

4. Application materials:
- Fellows must submit this form and a letter from their program directors verifying training status.
- Applicants for all other categories:
  - Submit *curriculum vitae* including your publications, scientific exhibits and honors in medicine including Pediatric Radiology.
  - Names of two Active members of the Society for Pediatric Radiology who will write letters of recommendation for you. If applicant is a member in good standing of ESPR and is applying for Corresponding membership, letters of recommendation are not necessary.
    - ____
      Name Institution City, State
    - ____
      Name Institution City, State

(Please continue on reverse side)

6. Medical Education:

a. Medical School ____
Institution | Location (city, state) | Degree | Date Completed

b. Internship ____
Institution | Location (city, state) | Type | Date Completed

c. Residency ____
Institution | Location (city, state) | Type | Date Completed

d. Training in Pediatric Radiology (other than included in 6b and 6c):

____
Institution | Location (city, state) | Type | Begin/End Date | Prog Director

____
Institution | Location (city, state) | Type | Begin/End Date | Prog Director

Note: If you have not had separate and specific training in Pediatric Radiology but wish to submit what you consider equivalent qualifications, please describe them in detail on a separate page. Describe type of experience, location, dates, supervision, your responsibilities, percentage of time in pediatric patient care, teaching and research.

7.Licensed to practice medicine in: ______________________ License No.______________________
List all

8. Board Certification ***(Status required)***

a. American Board of Radiology ☐ Yes - date certified __________ ☐ No Comment: ______________________

b. Equivalent certification in Radiology (e.g. Royal College of Physicians and Surgeons of Canada, College of P&S of Quebec, etc.)

Specify Board: ______________________ Date certified ______________________

c. Other certification: ______________________ Date certified: ______________________

9. Current Pediatric Radiology practice status:

a. ____
Institution | Address | Date started in practice

____
Institution | Address | Date started in practice

b. What percentage of your non-administrative professional time is spent in the practice of Pediatric Radiology? (including all forms of diagnostic Imaging, radiation therapy, teaching and research)? % __________

10. Please indicate your practice type below:

☐ Community Hospital -Based ☐ Children's Hospital-Based ☐ University Hospital-Based
☐ Other: ______________________

I understand that it is my responsibility for the required applications materials to be mailed directly to the Chairman of the Membership Committee at the Society address as indicated on the reverse of this form (*or the sealed sponsor letters may accompany the application form*) and that the Society for Pediatric Radiology will not act on my application until these letters are received.

I understand and agree that the Society for Pediatric Radiology may receive information and make inquiry concerning my professional ability, qualifications and fitness for membership and I agree that I will make no claim against the Society or any person or organization who in good faith, furnishes information to the Society or takes action concerning my application for membership or my continued membership in the Society.

Signed ______________________ Date: ______________________
Applicant Signature