The Society for Pediatric Radiology

1891 Preston White Drive Reston, VA 20191

www.pedrad.org

spr@acr.org

● MEMBER-in-TRAINING APPLICATION ●

Request appropriate membership category by checking one below:

Members-in-Training are Medical students, residents and pediatric radiology fellows who have applied for membership. Member-in-Training membership is effective immediately upon receipt of a complete application form indicating eligibility for membership in training status. The completed application includes a letter from the training director verifying training status.

When all required training is complete Member-in-training shall be presented to the membership for election to be an Active member. A Member-in-training shall have all the privileges of Active membership except those that are a benefit paid for by dues; s/he shall not have a vote nor hold any office of this Corporation. S/he shall not pay dues while a Member-in-training. A Member–in-Training will pay reduced registration fees for the educational activities of the Society.

PLEASE COMPLETE: (type or print)

APPLICATION DATE: _____

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

Gender: ☐Male ☐Female ● Birth Date_____ ● Email_____
(Preferred Email address)

2. Contact information (*for directory listing, correspondence, and journal subscription*):

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 Work Email address

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

3. Medical Education:

a. Institution _____
Institution Location (city, state) Degree Date Completed

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

4. Radiology Residency Education (if any):

_____
Institution Location (city, state) Type Date Completed

● MEMBER IN TRAINING APPLICATION CONTINUED ●

5. Fellowship Training in Pediatric Radiology (if any):

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

5. Licensed to practice in: _____License No._____

List all

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

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

b. Equivalent/appropriate certification (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: _____

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.

Sign: _____ Date: _____

Applicant Signature

Applications and program director verification letters may be emailed to: spr@acr.org

The Society for Pediatric Radiology
Membership Department
1891 Preston White Drive
Reston, VA 20191

FAX to: 703-264-2093