• MEMBERSHIP APPLICATION •

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

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 radiation 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. (Complete all questions.)

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_____
Check if employed full time by: ☐ US Military (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 Education:

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

b. Training in Pediatric Radiology:

_____
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.

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: _____

7. Please submit your *curriculum vitae* including your publications, scientific exhibits and honors in medicine including Pediatric Radiology.

8. Names of two Active members of the Society for Pediatric Radiology who will vouch for you. Letters of recommendation are no longer necessary.

a. _____
Name Institution City, State

b. _____
Name Institution City, State

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 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 may be mailed to:	The Society for Pediatric Radiology Membership Department 1891 Preston White Drive Reston, VA 20191	Emailed to: spr@acr.org FAX to: 703-264-2093