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

● ALLIED HEALTH MEMBERSHIP APPLICATION ●

Indicate Profession by checking one below:

☐ **Radiologist Assistant**
I received my Registered Radiologist Assistant (RRA) certification from the ARRT on Date: _____

☐ **Physician Assistant**
I received my certification _____ from _____ Date: _____

☐ **Nursing Degree _____Univ or College_____ Date: _____**

☐ **Other** Profession_____**

I am certified in _____by Certifying Body:_____Date: _____

**Please submit copies of notifications of certifications with application.

PLEASE COMPLETE: (type or print)

APPLICATION DATE: _____

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

Gender: ☐Male ☐Female ● Email _____ ● Birth Date_____

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 Work Email address

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

Rev. 6/2013

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: 703-264-2093