

## 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 (RRA) certification from the AART on \_\_\_\_\_ Date \_\_\_\_\_

**Other\*\*:** Profession: \_\_\_\_\_

I am certified in \_\_\_\_\_ by Certifying Body: \_\_\_\_\_ Date \_\_\_\_\_

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

*\*\* Please note: Applications submitted under the category of "Other" must be approved for membership by the Commission on Membership and Communications before ACR and Chapter membership can be granted.*

**NOTE:** Applicants practicing in the U.S. must also belong to a College chapter. Chapter membership is optional for active employees of the U.S. military services and the USPHS This application is also an application for chapter membership. Applicants practicing in Canada must belong to the Canadian Association of Radiologists (CAR). Call the CAR at 613-860-3111 to join the CAR or to verify your CAR membership.

**Please print or type.**

Applicant's Name in Full \_\_\_\_\_ Degrees \_\_\_\_\_  
Last First Middle (MD, PhD, MB, etc.)

Former Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Address \_\_\_\_\_ Business Address \_\_\_\_\_

City \_\_\_\_\_ City \_\_\_\_\_

State/Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

Country \_\_\_\_\_ Country \_\_\_\_\_

**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, 2007 (Res. 36-a).

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Home Fax \_\_\_\_\_ Business Fax \_\_\_\_\_

Gender  M  F Birth Date\* \_\_\_\_\_ Social Security Number/Social Insurance Number (Last 4 digits)\* \_\_\_\_\_

Check if employed full time by:  Veterans Admin.  USPHS  Army  Navy  Air Force  Marines

**Training**

Name of Institution \_\_\_\_\_

Specialty \_\_\_\_\_ Yr Grad \_\_\_\_\_

**Additional Training**

Name of Institution \_\_\_\_\_

Specialty \_\_\_\_\_ Yr Grad \_\_\_\_\_

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

