



**American Alliance of Academic Chief Residents in Radiology (A<sup>3</sup>CR<sup>2</sup>)**  
**2009-2010 Membership Application and Biographical Data Form**

Name in Full: \_\_\_\_\_ Degree: \_\_\_\_\_

Dept/Institution: \_\_\_\_\_

Address: \_\_\_\_\_ Birth (mm/dd/yy): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

PREFERRED ADDRESS FOR CORRESPONDENCE AND JOURNAL (if different from above):

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Please complete:** Medical School: \_\_\_\_\_ (Place) \_\_\_\_\_ (Graduation Year)  
Internship: \_\_\_\_\_ (Place) \_\_\_\_\_ (Dates)  
Residency: \_\_\_\_\_ (Place) \_\_\_\_\_ (Dates- include completion date)

**Membership dues payment of \$85 (A<sup>3</sup>CR<sup>2</sup> Alliance Fee \$25 and AUR Membership dues \$60) must accompany application when submitted. Membership in the AUR is required.**

Check payable to AUR (US funds, drawn on a US bank) in the amount of \$\_\_\_\_\_.

By sending your check to us, you authorize AUR to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

Please charge the amount of \$\_\_\_\_\_ to the following:

MasterCard  Visa Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Signature: \_\_\_\_\_

**Please return completed form to:**

**AUR Membership Office**  
**820 Jorie Boulevard**  
**Oak Brook, IL 60523**  
**Phone: (630) 368-3730**  
**Fax: (630) 571-7837**  
**E-mail: AUR@rsna.org**