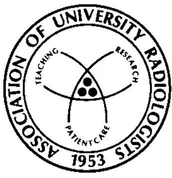

American Alliance of Academic Chief Residents in Radiology (A^3CR^2)
2010-2011 Membership Application and Biographical Data Form

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 must accompany application when submitted.

\$95 (A^3CR^2 Alliance Fee \$35 and AUR Membership dues \$60) if payment is received between July 1 and December 31
\$65 (A^3CR^2 Alliance Fee \$35 and AUR Membership dues \$30) if payment is received between January 1 and June 30

Membership in the AUR is required.

Signature: I, the undersigned, submit this application form for consideration by the AUR Membership Committee and recommend the candidate for participation in this program.

1. ______________________________ ______________________________
Signature of Program Director (for resident/fellow applicants) (Name-typed)

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

(Rev.4.13.10)