



The Association of University Radiologists
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: _____

Medical School: _____ (Graduation Year)

Post graduate: _____ Year(s) _____ Year(s)

Training: _____ Year(s) _____ Year(s)

Subspecialty (Please choose your primary):

- | | | | | |
|----------------------|---------------------------|--------------------|---------------------|---------------------------|
| Breast/Mammography | Gastrointestinal | Informatics | Nuclear Medicine | Ultrasound |
| Cardiac Radiology | General | Magnetic Resonance | Pediatric Radiology | Vascular & Interventional |
| Chest | Genitourinary | Molecular Imaging | Radiation Oncology | Whole-Body Imaging |
| Computed Tomography | Head & Neck | Musculoskeletal | Radiation Physics | |
| Diagnostic Radiology | Health, Policy & Practice | Neuroradiology | Radiobiology | |

Please list Present and Past Academic Appointments

_____	_____	_____
_____	_____	_____
(Institution)	(Rank)	(Month/Year)

The AUR Bylaws specify that candidates for membership be nominated by one AUR members (Full or Emeritus):

Signatures: I, the undersigned, submit this application for consideration by the Membership Committee and recommend him/her as a Member of AUR.

(AUR Member Sponsor Signature)

(Name-typed)

This individual holds a faculty appointment in our department.

Department Chair (Signature)

(Name-typed)

OPTIONAL: Indicate your interest in AUR Alliance participation. At this time AUR has organized Alliances for members interested in career advancement as a clinician-educator (Alliance of Clinician-Educators in Radiology - ACER), for members who are directors of medical student radiology education programs or members who play a significant role in the radiology education of medical students (Alliance of Medical Student Educators in Radiology – AMSER), for members who are involved in health services research (Radiology Alliance for Health Services Research – RAHSR), and for members who serve as research directors or members who play a significant role in fostering radiology research for their departments (Radiology Research Alliance – RRA).

Alliance fees are \$75 for AMSER, \$50 for ACER, RAHSR, and RRA. Please submit your Alliance fee(s) with your dues payment.

- I am interested in ACER participation.
- I am interested in AMSER participation.
- I am interested in RAHSR participation.
- I am interested in RRA participation.

**Association of University Radiologists
Application for Membership Instructions**

1. All radiology faculty of an accredited medical school or of an institution with an ACGME-approved radiology residency or fellowship program, whether or not it is university based, and faculty in programs applicable to or related to the radiologic sciences are eligible for membership.
2. The applicant must spend at least a majority of his or her time in the teaching of medical students or residents, patient care related to teaching activities, research, or attendant administrative duties. This level of activity must be attested to by the dean, director or chief executive of the institution or chair of the department in the application for membership and must be continued for retention of membership in the Association.
3. A Full or Emeritus member of the AUR may submit nominations for membership.
4. Applicants who are interested in participating in one of the AUR Alliances should be actively involved in the endeavor for which the Alliance is organized.
5. Please complete the following applicant pledge.
If elected to membership, I agree to abide by the Bylaws and Regulations of the Association of University Radiologists and such changes and amendments as may hereafter be properly adopted. I hold a faculty position in the

Department of _____ at the

_____ with a time distribution of my effort as described above.

(Institution)

(Signature of applicant)

(Date)

Re-application by Former Members:

Please fill out a new application form and have the university write a letter attesting to faculty status. No sponsoring signatures are required.

Dues must accompany application when submitted. Membership dues are \$260.00* for applications received between July 1 and December 31 (of which \$60.00 is applied toward a subscription to the official journal of the AUR, *Academic Radiology*) and \$130.00* for applications received between January 1 and June 30 (of which \$30.00 is applied toward a subscription to *Academic Radiology*).

* This amount is subject to change and does not include the modest Alliance participation assessment.

Enclosed is my check payable to AUR (US funds, drawn on a US bank) for Membership Dues 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 my Membership Dues in 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**