



American Alliance of Academic Chief Residents in Radiology (A³CR²)
2017-2018 Membership Application and Biographical Data Form



Name in Full: _____ Degree: _____

Dept/Institution: _____

Address: _____ Birth (mm/dd/yy): _____

City, State, Zip: _____

Office Phone: _____ 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 in the AUR is required in order to participate in A³CR². Please submit A³CR² fee and AUR membership dues payment with application. If you are unsure of your AUR membership status, contact the AUR Office.

_____ Full Year Membership \$135
 July 1, 2017 through June 30, 2018
 (AUR Dues \$60 and A³CR² Fee \$75)

_____ Partial Year Membership \$105*
 January 1, 2017 through June 30, 2017
 (AUR Dues \$30 and A³CR² Fee \$75)

_____ I am currently a chief resident.

*New Members Only

_____ I am a former chief resident.

Signature: I, the undersigned, submit this application form for consideration by the AUR Membership Committee and recommend the candidate for participation in the AUR and A³CR².

 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 # _____ CVV Code: _____ Exp. Date: _____

Name on Card: _____ Signature: _____

Any questions, please contact AUR@rsna.org

Please return completed form to: AUR Membership Office
 820 Jorie Boulevard
 Oak Brook, IL 60523

Phone: 1-630-368-3730 Fax: 1-630-571-2198