Association of University Radiologists

2017-2018 Associate Membership Application and Biographical Data Form

Name in Full: _____ **Degree:** _____

Dept/Institution: _____

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

City, State, Zip/Postal Code: _____

Office Phone: _____ **E-mail Address:** _____

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

Address: _____ City, State, Zip/Postal Code: _____

Field of Study:
- ☐ Information Technology Specialist
- ☐ Radiology Nurse/Technologist
- ☐ Radiology Administrator
- ☐ Residency Program Coordinator (Non-physician)
- ☐ Medical Student Curriculum Coordinator (Non-physician)

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

Training: _____ Year(s) _____ Year(s)
(If applicable)

Please list Present and Past Academic Appointments

(Institution)	(Rank)	(Month/Year)

OPTIONAL: Indicate your interest in AUR Affinity Group participation. At this time, AUR has organized Affinity Groups for members interested in career advancement as a clinician-educator (Alliance of Clinician-Educators in Radiology - ACER), for 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)**.**

Please submit your Affinity Group fee(s) with your dues payment.

- ❑ I would like to join **AMSER**. I am a Medical Student Curriculum Coordinator. **($20 Fee)**
- ❑ I would like to join **AMSER**. **($75 Fee)**
- ❑ I would like to join **ACER**. **($75 Fee)**
- ❑ I would like to join **RAHSR**. **($50 Fee)**
- ❑ I would like to join **RRA**. **($50 Fee)**

Association of University Radiologists
Application for Associate Membership Instructions

1. All radiology residency/fellowship program coordinators, radiology medical student curriculum coordinators, computer support personnel, radiology administrators, radiology nurses or technologists, in an accredited medical school, in an institution with a radiology residency or fellowship program, whether or not it is university based, or in a program applicable to or related to radiology or radiologic sciences will be eligible for associate membership.

2. The applicant must attest to the level of activity and the level of activity must be continued for retention of membership in AUR.

3. Applicants who are interested in participating in one of the AUR Affinity Groups should be actively involved in the endeavor for which the Affinity Group is organized.

4. Please read the following pledge and check box below to agree:

☐ 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.

Re-application by Former Members:

Please fill out a new application form. Former members do not qualify for half year membership.

Dues must accompany application when submitted.
Membership dues are $97.00* and run the academic year of July 1, 2017 to June 30, 2018.

New members applying for membership between January 1, 2018 to June 30, 2018, are eligible for half year membership dues of $48.50*. Former members do not qualify for half year membership.

($60.00 for full year or $30 for half year is applied toward a subscription to the official journal of the AUR, *Academic Radiology*).

* This amount is subject to change and does not include the modest Affinity Group 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 # _____ 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