ASSOCIATION OF UNIVERSITY RADIOLOGISTS
PROGRAM VERIFICATION

Email or fax completed verification form to AUR Membership at customerservice@rsna.org or 630-590-7712 (fax).

NAME & INSTITUTION
The following individual is currently enrolled in medical school or formal radiologic training program:

Full Name (print):__________________________________________
Name of institution:________________________________________

PROGRAM TYPE
☐ Medical School
☐ Internship
☐ Residency (indicate residency program type)
   ☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology
☐ Fellowship (indicate fellowship program type)
   ☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology

PROGRAM DATES
Begin date: [mm/dd/yyyy] _____ / _____ / _____
Anticipated completion date: [mm/dd/yyyy] _____ / _____ / _____

CHIEF RESIDENCY
☐ I am a chief resident.
Begin date: [mm/dd/yyyy] _____ / _____ / _____
End date: [mm/dd/yyyy] _____ / _____ / _____

VERIFICATION
Program director or coordinator must verify that individual is enrolled in medical school or formal radiologic training program by printing and signing below:

Printed name of director or coordinator of current program
__________________________________________________________

X
Signature of director or coordinator of current program
__________________________________________________________

AUR Membership
Phone: 1-877-776-2636
or 1-630-571-7873 outside the USA and Canada