

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