

ASSOCIATION OF UNIVERSITY RADIOLOGISTS PROGRAM VERIFICATION

Email the completed verification form to info@aur.org.

NAME & INSTITUTION

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

Full Name (print): _____

Academic degree(s): _____

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: [month/day/year] ____ / ____ / ____

Anticipated completion date: [month/day/year] ____ / ____ / ____

CHIEF RESIDENCY

- I am a chief resident.
Begin date: [month/day/year] ____ / ____ / ____
End date: [month/day/year] ____ / ____ / ____

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