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