ARRS
Your Medical Imaging Society
CONNECT · LEARN · ADVANCE

In-Training Membership Application

For ARRS office use: WEB21

Date Received_____

ID#_____

Members are eligible to participate in all ARRS activities including holding elective office and voting. Membership is effective upon processing of completed application and activation of the member account. Membership applications are received daily throughout the year and are processed in the order received. Please allow 2–4 weeks for processing.

A. SELECT MEMBERSHIP TYPE (RESIDENT, FELLOW, OR MEDICAL STUDENT) AND COMPLETE INDICATED INFORMATION

☐ **RESIDENT APPLICATION**—I certify I am in a residency at _____
Name of Institution

Date Program Began/Begins:_____ Date Program Ends:_____
Month/Date/Year Month/Date/Year

Medical School Name:_____ Graduation Date:_____
Month/Date/Year

☐ **FELLOW APPLICATION**—I certify I am in a _____ fellowship at
Specialty

_____
Name of Institution

Date Program Began/Begins:_____ Date Program Ends:_____
Month/Date/Year Month/Date/Year

Medical School Name:_____ Graduation Date:_____
Month/Date/Year

Completed Residency at:_____
Name of Institution

Residency End Date:_____
Month/Date/Year

Program Director or Department Chair Verification

I certify this applicant is a ☐ resident *or* ☐ fellow *at the above-named institution.*

Program Director/Department Chair Name:_____

Email:_____ Phone:_____

Program Director/Department Chair Signature:_____

☐ **MEDICAL STUDENT APPLICATION**—I certify I am attending medical school at:

_____
Name of Institution Location

Date Program Began/Begins:_____ Date Program Ends:_____
Month/Date/Year Month/Date/Year

Dean of Medical School Verification

I certify this applicant is a medical student at the above-named institution.

Name of Dean of Medical School:_____

Email:_____ Phone:_____

Dean of Medical School Signature:_____

B. CONTACT AND DEMOGRAPHIC INFORMATION

First Name Middle Name Last Name Degree(s)

Birthdate (Month/Date/Year):_____ ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer

Home Street Address: _____

City State/Province Zip/Postal Code Country

Home Email:_____ Home or Cell Phone:_____

Employer Name:_____

Work Street Address:_____

City State/Province Zip/Postal Code Country

Work Email:_____ Work Phone:_____

Please indicate where you prefer to receive print member correspondence: ☐ Home ☐ Work
Please indicate where you prefer to receive email member correspondence: ☐ Home ☐ Work

Occasionally ARRS rents mailing lists to companies with radiology-related products and services. If you prefer to exclude your name and mailing address from these list rentals, please check here. ☐

C. CHOOSE ONLINE ONLY OR PRINT AND ONLINE MEMBERSHIP AND AUTHORIZE APPLICATION WITH SIGNATURE

In-training members (residents, fellows, and medical students) selecting Online Only will have online access to the Society's medical journal. The Print and Online option is only available to in-training members who are in training for more than 6 months beyond the date of this membership application.

Online Only *(all countries)* ☐ $0 during training

Print and Online ☐ $95 per year to receive print medical journal
(Applicant is located in North America, including United States territories)

Print and Online ☐ $175 per year to receive print medical journal
(Applicant is located outside North America)

If selecting Print and Online:

☐ Visa ☐ MasterCard ☐ American Express ☐ Check (Payable to ARRS in U.S. funds)

Card No: | | | | | | | | | | | | | | | | Expires: | | | |

Send completed form by mail or fax:

ARRS
Attn: Member Services
44211 Slatestone Court
Leesburg, VA 20176-5109 U.S.A.
Fax: (703) 729-4839

Questions:
Email: membership@arrs.org
Toll-free: (866) 940-2777 (U.S. and Canada)
Phone: (703) 729-3353

Apply online at: arrs.org

Sign below to indicate the information provided is correct to the best of your knowledge and, if applicable, to authorize payment information indicated in Section C.

Applicant's Signature: _____ Date: _____