ACR/Chapter Application for Membership

I am a:

☐ Diagnostic radiologist ☐ Interventional radiologist ☐ Radiation oncologist ☐ Nuclear medicine physician ☐ Medical physicist

Please check the category of membership for which you are applying:

☐ **Member.** I am certified by the ☐ ABMP ☐ ABNM ☐ ABR ☐ ABSNM ☐ AOBR ☐ CCPM
☐ RCPS (Canada) ☐ Collège des médècins du Québec Date Certified _____

☐ **Associate Member.** I practice radiology/radiation oncology/radiological physics/nuclear medicine on a full-time basis. I am **board-eligible**, but not certified by the ABMP, ABNM, ABR, ABSNM, AOBR, CCPM, RCPS, or the Collège des médècins du Québec.

NOTE: Applicants practicing in the U.S. must also belong to a College chapter (this application also works for chapter membership). Chapter membership is optional for active employees of the U.S. military services and USPHS. Applicants practicing in Canada must belong to the Canadian Association of Radiologists (CAR). To join CAR or verify your membership with them, call **613.860.3111**.

Please print or type.

Full Name _____ Degrees _____
First Middle Last (MD, PhD, MB, etc.)

Former Name _____ Email Address _____
Email: ☐ Home ☐ Business

Gender ☐ M ☐ F Birth Date* _____ SSN/SIN (Last 4 digits)* _____

*Birth date and Social Security Number/Social Insurance Number (Last 4 digits) are used to uniquely identify you in our database.

Home address will be used for mailings.
Billing Address: ☐ Home ☐ Business

Home Address _____

_____

City _____

State/Province _____ ZIP/Postal Code _____

Country _____

Home Phone _____

Home Fax _____

Cell Phone _____

Business information will be used for Membership Directory, per ACR Council 1987 resolution, amended 1997, 2007 (Res. 36-a).

Business Address _____

_____

City _____

State/Province _____ ZIP/Postal Code _____

Country _____

Business Phone _____

Business Fax _____

Check if employed full time by: ☐ Veterans Admin. ☐ USPHS ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard

All applicants must report all qualifying training in the appropriate fields below:

Residency Training

Name of Institution _____

Specialty _____ Yr Grad _____

Fellowship Training

Name of Institution _____

Specialty _____ Yr Grad _____

Other Training

Name of Institution _____

Specialty _____ Yr Grad _____

Disciplinary History — If yes, please explain the circumstances and outcome in the area provided below.

YES NO

1. ☐ ☐ Have you ever been convicted of a felony or misdemeanor under any federal, state or local law, pled "no contest" or "nolo contendere" or entered into a plea bargain regarding such felony or misdemeanor?
2. ☐ ☐ Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any medical school, residency or fellowship training, hospital, nursing home, health care facility or health care provider?
3. ☐ ☐ Have you ever had any of the following disciplinary actions taken against your license to practice medicine, DEA permit, state controlled substances registration, Medicaid, or are any such actions pending? (Check all that apply.)

   ☐ Suspension/revocation ☐ Reprimand/cease and desist ☐ Limitation placed on scheduled drugs
   ☐ Probation ☐ Had your practice monitored
4. ☐ ☐ Have you ever surrendered a state medical license while under investigation or in lieu of investigation or disciplinary action?
5. ☐ ☐ Have you ever had any membership in a national, state or local professional society revoked, suspended or sanctioned?
6. ☐ ☐ Have you voluntarily withdrawn from any professional society while under investigation or in lieu of disciplinary action?

Explanation:

I agree to abide by the current bylaws, policies and procedures of the College and the Association and any future revisions thereof.
I hereby certify that the information given above is correct to the best of my knowledge.

Signature of Applicant _____ Date _____

How did you hear about the ACR?

☐ Colleague ☐ Email ☐ Mail ☐ Online Advertising ☐ Phone Call ☐ Print Ad ☐ Social Media

Important: Please complete if referred by an ACR Member

Referring Member ID: _____

Referring Member Email Address: _____

Referring Member First Name: _____

Referring Member Last Name: _____

Referring Member City: _____

Referring Member State: _____

Referring Member Country: _____

Marketing Code: _____

Payment Information

$12 of your ACR membership dues will be allocated to an ACR Bulletin *annual subscription.*

For security reasons, do not provide payment information when returning a completed application via fax or email. Credit card information should be provided directly to ACR Membership Services staff by phone at **1·800·347·7748**. Providing credit card information by fax or email is at your own risk.

☐ Check payable to **ACRA***

Credit Card
☐ American Express (15 digits)
☐ MasterCard (16 digits)
☐ Visa (13 or 16 digits)

Credit Card No. | | | | | | | | | | | | | | | | |

Expiration Date | | | — | |

Cardholder's Name _____
(please print)

Cardholder's Signature _____

***Enclose check payable to ACRA** to cover both ACR/ACRA and chapter dues. Refer to Dues Schedule (In AR, CA, Canada, FL, NJ, PA attach only ACRA payment — chapter will bill you separately).

Mail application and payment to:
Membership Services • American College of Radiology • 1891 Preston White Dr. • Reston, VA 20191-4326

Phone: 703·648·8900, ext. 4064 • 1·800·347·7748 • **Fax:** 703·264·2093 • **Email:** membership@acr.org