ACR® AMERICAN COLLEGE OF RADIOLOGY
QUALITY IS OUR IMAGE

ACRA® AMERICAN COLLEGE OF RADIOLOGY ASSOCIATION

Application for Membership

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 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. Chapter membership is optional for active employees of the U.S. military services and the U.S.P.H.S. This application is also an application for chapter membership. Applicants practicing in Canada must belong to the Canadian Association of Radiologists (CAR). Call the CAR at 613·860·3111 to join the CAR or to verify your CAR membership.

Please print or type.

Applicant's Name in Full _____ Degrees _____
Last First Middle (MD, PhD, MB, etc.)

Former Name _____ Email Address _____

Home Address _____ Business Address _____

_____ _____

City _____ City _____

State/Province _____ ZIP/Postal Code _____ State/Province _____ ZIP/Postal Code _____

Country _____ Country _____

Home address will be used for mailings. **Billing Address**: ☐ Home ☐ Business
Business information will be used for Membership Directory, per ACR Council 1987 resolution, amended 1997, 2007 (Res. 36-a).

Home Phone _____ Business Phone _____

Home Fax _____ Business Fax _____

Gender ☐ M ☐ F Birth Date* _____ Social Security Number/Social Insurance Number (Last 4 digits)* _____

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

Residency Training

Name of Institution _____

Specialty _____ Yr Grad _____

Fellowship Training

Name of Institution _____

Specialty _____ Yr Grad _____

*Birth date and social security number are used to uniquely identify you in our database.

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.

Required — Two Chapter Sponsor Signatures**

You must join the chapter 1) where you conduct your principal practice, 2) where you reside or 3) located within 25 miles of either location. To join, please obtain the signatures of two people who are active members in good standing of the chapter for which you are applying.

_____ _____

Signature of First Sponsor Signature of Second Sponsor

_____ _____

Legibly Printed Name of First Sponsor Legibly Printed Name of Second Sponsor

I herby certify that the information given above is correct to the best of my knowledge.

Signature of Applicant _____ Date _____

**Note: See Dues Schedule for chapters that do not require sponsors.

****Radiation Oncologists:** ACR Bylaws provide that as a member of CARROS (Council of Affiliated Regional Radiation Oncology Societies), you may elect to be state chapter inactive — no sponsor signatures (see above) are required. **You are still liable for state chapter dues. You may not vote or hold state chapter office.**

Check here to be state chapter inactive ☐

Payment Information

$12 of your $850 ACR membership dues is allocated to an ACR Bulletin annual subscription.

☐ 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

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

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