ACR® AMERICAN COLLEGE OF RADIOLOGY
QUALITY IS OUR IMAGE

ACRA® AMERICAN COLLEGE OF RADIOLOGY ASSOCIATION

Application for Allied Health Membership/ Chapter Application for Membership

I am a:

☐ **MRI Scientist**

I am certified by: Certifying Body _____ Date Certified _____

Other Certification: Certifying Body _____ Date Certified _____

☐ **Radiologist Assistant**

I received my Registered Radiologist Assistant (RRA) certification from the ARRT on Date _____

☐ **Other**: Profession:** _____

I am certified in _____ by Certifying Body: _____ Date _____

(Please submit copies of notifications of certifications with application.)

*** Please note: Applications submitted under the category of "Other" must be approved for membership by the Commission on Membership and Communications before ACR and Chapter membership can be granted.*

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 USPHS 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.

Full Name _____ Degrees _____
First Middle Last (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 ☐ Coast Guard

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

Training

Name of Institution _____

Specialty _____ Yr Grad _____

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

Signature of Applicant _____ Date _____

Payment Information

$12 of your $235 ACR membership dues is 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 enclosed 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**