

The Southeastern Neuroradiological Society
MEMBERSHIP APPLICATION

Name: _____ Date: _____

Date of Birth: _____

Address:

Home: _____

Work: _____

Telephone: (Home) _____ (Work) _____ (FAX) _____

(E-mail) _____

1. Medical School _____

2. Residency in Radiology, From: _____ To: _____

A) Institution: _____

3. Neuroradiology Fellowship, From: _____ To: _____

A) Institution: _____

B) Director of Fellowship: _____

4. A) Certification by American Board of Radiology: _____ Date: _____

B) Certification by other Specialty Board(s): _____ Date: _____

C) CAQ in Neuroradiology: _____ Date: _____

5. Non-Fellowship Neuroradiology experience after residency:

	Institutions	Dates	Percentage of time devoted to Neuroradiology
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

(2 Letters of Recommendation – have letters mailed to address below)

6. Members of the Southeastern Neuroradiological Society or Senior members of the American Society of Neuroradiology with whom you have worked or who are familiar with your work and a letter from the director where you completed your neuroradiology fellowship.

	Name	Address
1.	_____	_____
2.	_____	_____

7. Present professional practice:

A) Full time university faculty? _____

Faculty appointment: _____

B) Private office or hospital? _____

Clinical faculty appointment: _____

C) Other (describe) _____

8. Are you a member of the American Society of Neuroradiology?

Category _____

9. Please attach CV.

Membership Chairman
Southeastern Neuroradiological Society
2775 Jasmine Ct., NE
Atlanta, GA 30345

Signature