2017-2018 International Membership Application

Name in Full: _____ **Degree:** _____

Department/Institution: _____

Address: _____ **Birth (mm/dd/yy):** _____

City, State, Zip/Postal Code: _____ **Country** _____

Office Phone: _____ **E-mail Address:** _____

Position: ☐Program Director ☐Co-Director ☐Assistant/Associate ☐Other (*please specify)*:_____

Type of Director: ☐Residency ☐Fellowship **#Residents/Fellows Approved for:** _____

Type of Fellowship: ☐Neuroradiology ☐Nuclear Radiology ☐ Other (*please specify*):_____

I am currently a member of: ☐ SCARD ☐ AUR

The APDR is incorporated in the state of Illinois under Section 501(c)(3) of the Internal Revenue Code of 1986 as a non-profit corporation exclusively for charitable, educational and scientific purposes.

Please read the following and mark an 'X' in the box to agree:

☐ I agree to abide by the Bylaws and Regulations of the Association of Program Directors in Radiology and such changes and amendments as may hereafter be properly adopted.

Dues must accompany application when submitted. All memberships run October 1, 2017 to September 30, 2018. Completed form must be accompanied by a $50 application fee and the first year's dues payment of $250 for a total payment of $300.00. Please make checks payable to APDR.

PAYMENT INFORMATION (in US funds drawn on a US bank)**:** ☐**Check enclosed** ☐**MasterCard** ☐**Visa**

By sending your check to us, you authorize APDR to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

☐ I authorize the Association of Program Directors in Radiology to charge my credit card $300.00.

Card Number

CVV Code

Expiration Date (MM/YY)

_____

Name as it appears on card

Contact APDR at 1-630-368-3737 or *APDR@rsna.org* with any questions.

Please return completed application with payment to:
APDR Membership Office, 820 Jorie Boulevard, Oak Brook, IL 60523
Secure Fax: 1-630-571-2198