



**MEMBERSHIP APPLICATION**  
(please legibly print or type all information)  
**Application Deadline: August 1, 2008\***

Indicate category applying for:       Senior                       Associate                       Corresponding

1. Applicant's name \_\_\_\_\_  
First/Middle/Last/Degree

Institution \_\_\_\_\_ Home address \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

2. Indicate with an "X" all of the following societies of which you are a member:  
\_\_\_\_ ASNR    \_\_\_\_ ASFNR    \_\_\_\_ ASHNR    \_\_\_\_ ASPNR    \_\_\_\_ ASSR

**IMPORTANT:**

- ◆ **If you are a member of any of the societies listed under #2 (above),** proceed to # 8... sign and date the application, and provide the appropriate amount of prorated dues -- you do NOT need to complete sections 3-7 of this application. **If applying for Senior status, provide a copy of your Radiology Board or Subspecialty Certification (formerly CAQ) certificate.**
- ◆ **If you are NOT a member of any of the societies listed under #2,** you *must* complete the entire application, provide the required documentation and appropriate prorated dues. Incomplete applications will not be processed.

**3. Sponsors: Applicants must be sponsored in writing by two (2) WNRS Senior Members, or the equivalent for ASNR or an ASNR-managed specialty society listed above.**

Sponsor 1 \_\_\_\_\_ Sponsor 2 \_\_\_\_\_

Institution \_\_\_\_\_ Institution \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_ E-mail \_\_\_\_\_

**4. Postgraduate Education**

**a. Diagnostic Radiology**

1) Institution \_\_\_\_\_ Dates \_\_\_\_ to \_\_\_\_

Program Director Name \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

2) Institution \_\_\_\_\_ Dates \_\_\_\_ to \_\_\_\_

Program Director Name \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

**b. Neuroradiology Fellowship**

1) Institution \_\_\_\_\_ Dates \_\_\_\_ to \_\_\_\_

Program Director Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

2) Institution \_\_\_\_\_ Dates \_\_\_\_ to \_\_\_\_

Program Director Name \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

**5. Board Certification**  Yes  No \_\_\_\_\_  
 Certifying Board (e.g. American Board of Radiology) \_\_\_\_\_ Date \_\_\_\_\_

**6. Subspecialty Certification (Neuroradiology CAQ)**  Yes  No \_\_\_\_\_  
 Date \_\_\_\_\_

**7. State License**

_____	_____	_____
State	Number	Expiration
_____	_____	_____
State	Number	Expiration
_____	_____	_____
State	Number	Expiration

• Has Your License Ever Been Revoked or Suspended?  Yes\*  No  
 \* If "Yes", attach explanation

• Current Practice Description \_\_\_\_\_

8. Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**◆ IMPORTANT ◆**

<p><b>Members of ASNR, ASFNR, ASHNR, ASPNR, or ASSR, must submit the following:</b></p> <ol style="list-style-type: none"> <li>1. Application (<b>only</b> provide information for <b>sections 1, and 2, and 8 on the application</b>)</li> <li>2. Prorated membership dues (includes application fee)</li> <li>3. Copy of Radiology Board or Subspecialty Certification (formerly CAQ) certificate, if applying for <i>Senior</i> status</li> </ol>	<p><b>All other applicants must provide:</b></p> <ol style="list-style-type: none"> <li>4. Application (completed in its entirety)</li> <li>5. Two (2) Sponsor letters (refer to Sponsorship information)</li> <li>6. Current Curriculum Vitae</li> <li>7. Copy of Radiology Board or Subspecialty Certification (formerly CAQ) certificate, if applying for <i>Senior</i> status</li> <li>8. Prorated membership dues (which include the application fee for <i>Senior</i> status)</li> </ol>
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**◆ Prorated Membership Dues ◆**

Prorated dues include application fee.		1 <sup>st</sup> Qtr.	2 <sup>nd</sup> Qtr.	3 <sup>rd</sup> Qtr.	4 <sup>th</sup> Qtr. *
Category	Annual Dues	Jan-March	Apr-June	July-Sept	Oct-Dec
<i>Senior/Associate/Corresponding</i>	\$95 + \$75 application fee	\$170	\$147	\$123	\$170

\*When dues are paid during the 4<sup>th</sup> Quarter, membership is valid through December 31, 2008.

**Deadline for Membership Applications\***

If you wish to register for the WNRS 40<sup>th</sup> Annual Meeting your completed application, including required documentation and prorated dues, must be received by August 1, 2008. If you are not interested in attending the meeting, no deadline applies.

**Return completed application, prorated membership dues, and all required documentation to:**

Western Neuroradiological Society, 2210 Midwest Road, Suite 207, Oak Brook, IL 60523-8205  
 Phone: 630/574-0220 ext. 226; Fax: 630/574-0661; Email: kcammarata@asnr.org; Website: www.wnrs.org

# WNRS

2210 Midwest Road, Suite 207

Oak Brook, IL 60523-8205

PH: 630-574-0220 ext. 226 E-mail: kcammarata@asnr.org

## Credit Card Authorization Form

Please print all information below, and submit this form with your membership application. **All non-U.S. applicants are required to pay their prorated membership dues and application fee by credit card using this form.** Payment must accompany the application.

U.S. applicants may elect to pay by either check (made payable to the WNRS) or credit card, using this form.

**Please legibly print or type the information below:**

**Applicant's Name:** \_\_\_\_\_  
Name of Institution/Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Country (if other than U.S.): \_\_\_\_\_

Billing address, if different from above: Check one  *Home*  *Institution*  *Business Office*

Name of Institution/Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Country (if other than U.S.): \_\_\_\_\_

Indicate which *prorated* membership dues and application fee you are paying: \_\_\_\_\_

### ◆ Prorated Membership Dues ◆

Prorated dues include application fee		1 <sup>st</sup> Qtr.	2 <sup>nd</sup> Qtr.	3 <sup>rd</sup> Qtr.	4 <sup>th</sup> Qtr.*
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Credit Card (check one): \_\_\_\_\_ American Express \_\_\_\_\_ MasterCard \_\_\_\_\_ Visa

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_

Signature: \_\_\_\_\_

**If paying by credit card, this form must be included with your membership application.**

**Return applications and this form to:**

**Western Neuroradiological Society**

**2210 Midwest Road, Suite 207 ◆ Oak Brook, IL 60523-8205**