SOCIETY OF THORACIC RADIOLOGY MEMBERSHIP APPLICATION

Return the completed **application** and the **first 2 pages of your CV** (electronically) to: E-mail: str@thoracicrad.org



(Please complete ALL fields and PRINT the form)

Name:				
(First)	(MI)	(Last)	(Degree)	
Current Institution:				
Mailing Address:	(The second second second second	This is a second to the second	(D	
(address for delivery of the Journal o	or I noracic imaging and invoices)	This is my (Home □)	(Business) address	
(City)	(State)	(Zip/Postal Code)	(Country)	
Tel: (W):	(H):	(C):		
E-mail:				
Medical School:		Year completed:		
Residency:		Year complete	ed:	
Specialty:				
Board Certification: Board		Yea	Year:	
Fellowship:Year completed:			eted:	
Subspecialty:				
	For members-in	-training:		
Are you currently in a <i>cardiothoracic fellowship</i> : □Yes □ No		Date training is complete?		
Are you currently in-training? □Yes □ No		Date training is complete?		
Program Director Name:				
E-mail:				
By submitting this applicati	on, I attest that the above info	rmation and my Curriculum Vi	tae are correct.	
Please check the membersh	nip level below you are applyi	ng for.		
Dues for Senior Members / Associate Members:			10	
Dues for Members-in-training:	□ \$23	35		
Dues for Members-in-training who are cardiothoracic imaging fellows:		fellows:		
Please provide credit card in (Your payment will not be processed	nformation or enclose a check until membership is approved.)	k for membership dues		
Name as it appears on Credit	Card:			
VISA, MasterCard, or Discover No.:			Date:	