



MEMBERSHIP APPLICATION | Jan. 1 – Dec. 31

FULL PAYMENT MUST ACCOMPANY COMPLETED APPLICATION FORM

Membership Category — Select only one | Please print or type

- ACTIVE** — \$ 75/yr*
 CLINICAL ASSOCIATE — \$ 65/yr
 CORPORATE ASSOCIATE — \$ 65/yr
 STUDENT — \$ 45/yr
 INTERNATIONAL — \$85/yr
 *ACTIVE – Submit ARRT certification or Canadian equivalent

NAME Mr Mrs Ms FIRST _____ M.I. _____ LAST GENERATION (JR., SR., II, III) _____

CREDENTIALS _____ LICENSURE _____

DEGREE/S _____ REGISTRATION/S _____

Preferred Address Home Work

HOME STREET _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ EMAIL (for official avir business only) _____

WORK INSTITUTION NAME _____ DEPT. _____

STREET (include department, room number, mail stop codes, etc., if appropriate) _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ EMAIL EMAIL (for official avir business only) _____

Length of Time as Tech Area of Expertise: _____

Size of Institution (# of beds): _____
 Private _____ Academic _____

Number of Exams Performed at this Institution: _____
 Vascular _____ Interventional _____

Are You a Member of: ARRT Yes No **ASRT** Yes No
(If YES, please attach photocopy of membership card/s)

Other Professional Organizations of Which You Are a Member:

Related Interests (CQI, Teaching, Publishing, etc.):

Payment Information: Check Enclosed
Credit Card: AmEx MasterCard Visa

ACCT NUMBER _____

_____/_____/_____
EXP DATE

NAME ON CARD _____

SIGNATURE _____

STUDENT MEMBERS ONLY

DIRECTOR _____

PROGRAM ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____