Membership Application

Membership year is based on the anniversary of your join date

(Please print or type)

Membership Category: (Select only one, see reverse side for category descriptions/requirements.)

○ **Active ($75/yr)** ○ **Clinical Associate ($65/yr)** ○ **Student ($45/yr)** ○ **International ($85/yr)**

○ **Corporate Associate ($65/year)**

○ Mr ○ Mrs ○ Ms First Name_____ Middle Initial _____

Last Name_____ Generation _____
(JR., Sr., II, III)

Credentials_____ Licensure _____

Degree(s)_____ Registration(s) _____

Preferred Address: ○ Home ○ Work

Home
Address _____

City_____ State_____ Zip _____

Phone_____ Fax_____ Email _____
(Email addresses are used only for official AVIR business)

Work
Institution Name_____ Dept. Name _____

Street Address _____
(Include department, room number, mail stop codes, etc., if appropriate)

City_____ State_____ Zip _____

Phone_____ Fax_____ Email _____
(Email addresses are used only for official AVIR business)

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
NOTE: If YES, please attach photocopy of membership card(s)

List other professional organizations that you are a member of _____

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

STUDENT MEMBERS ONLY
Director _____ Program Address _____
City _____ State _____ Zip _____ Phone _____

Payment information: ○ *Check Enclosed* ○ *AMEX* ○ *MasterCard* ○ *Visa*

Acct Number: _____ *Exp* _____

Name on Card: _____ *Signature:* _____

All payments should be remitted to:
AVIR
2201 Cooperative Way, Suite 600
Herndon, VA 20171
Fax: 571-252-7174