



MASSACHUSETTS RADIOLOGICAL SOCIETY APPLICATION FOR STATE CHAPTER MEMBERSHIP

CHECK ONE:
 Physician
 Physicist

PLEASE CHECK THE MEMBER CATEGORY TO WHICH YOU ARE APPLYING:

- Resident/Fellow Member
- Active Member: I am a physician/physicist in the full-time practice of radiology/radiological physics and certified by the ABR, ABNM, RCPS or AOBR
- Associate Member: I am a physician/physicist in the full-time practice of radiology/radiological physics and not certified by the ABR, ABNM, RCPS or AOBR

NAME _____ DEGREES _____ BIRTHDATE _____
LAST FIRST MIDDLE MD, PhD, MB, etc. MO/DA/YR

HOME ADDRESS _____ OFFICE ADDRESS _____

CITY STATE ZIP CITY STATE ZIP

HOME PHONE _____ OFFICE PHONE _____ FAX _____ E-MAIL _____

PREFERRED MAILING ADDRESS: HOME OFFICE CITIZEN OF: US CANADA SEX: F M

COLLEGE(S) _____
INSTITUTION(S)/DEGREE(S) INTERNSHIP(S)

MEDICAL SCHOOL(S) _____
INSTITUTION(S)/DEGREE(S) INTERNSHIP(S)

RESIDENCIES IN RADIOLOGY/RADIOLOGICAL PHYSICS _____
FROM: MO/DA/YR TO: MO/DA/YR

PRESENT HOSPITAL APPOINTMENTS _____
FROM: MO/DA/YR TO: MO/DA/YR

LICENSED TO PRACTICE MEDICINE _____ DATE OF BOARD CERTIFICATION _____
STATE(S) AND DATE(S): MO/DA/YR MO/DA/YR

GRADUATE STUDIES IN HEALTH PHYSICS OR ALLIED HEALTH _____

CERTIFIED BY THE: ABR ABNM RCPS AOBR DATE: _____
MO/DA/YR

CURRENTLY IN FULL-TIME US GOVERNMENT SERVICE: VA ARMY NAVY USPHS AIR FORCE

CHAPTER SPONSORS: NAMES OF TWO CURRENT MEMBERS IN GOOD STANDING OF THE MASSACHUSETTS RADIOLOGICAL SOCIETY

1. _____ 2. _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE OF APPLICANT

DATE: MO/DA/YR

CHAPTER COPY - RETAINED BY SECRETARY