



ASSOCIATION OF PROGRAM DIRECTORS IN RADIOLOGY

820 JORIE BLVD, OAK BROOK, IL 60523

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2009-2010 APPLICATION FOR MEMBERSHIP

(Revised 05/2009)

Last Name _____ First Name _____ Middle _____ Degree: _____

Applicant's Position: _____ Program Director _____ Co-Director _____ Asst./Assoc. _____ Other _____

If other, please specify: _____ Birthdate(mm/dd/yy): _____

Type of Director (check one): Residency: _____ Fellowship: _____

Type of Fellowship: (check one):
_____ Neuroradiology _____ Nuclear Radiology
_____ Pediatric Radiology _____ V-I Radiology
_____ Other (please specify): _____

Program Name (ACGME Directory): _____

Program Number (ACGME Directory): _____ Approved for _____ (number of res./fellows)

Program Address: _____ Dept: _____

City: _____ State: _____ ZipCode: _____

Phone Number: _____ Fax Number: _____ E-mail _____

I am currently a member of (circle all appropriate organizations): SCARD AUR AMSER RRA RAHSR ACER

I **am** interested in serving as a guest examiner for the oral examination of The American Board of Radiology in the following category. (Guest examiners recommended by the APDR must fit into one of the following categories: a.) Current Residency Program Director, Co-Director, Associate or Assistant Director, b.) Past Residency Program Director, or c.) Current ACGME accredited Fellowship Director. Please note any board certified radiologist may apply directly to the ABR to be an oral examiner.) **Please circle only one category:**

Musculoskeletal Cardiopulmonary Gastrointestinal Genitourinary Neuroradiology
Vascular-Interventional Nuclear Radiology Ultrasonography Pediatric Radiology Breast Radiology

The APDR is incorporated in the state of Illinois under Section 501© (3) of the Internal Revenue Code of 1986 as a non-profit corporation exclusively for charitable, educational and scientific purposes.

I AGREE TO ABIDE BY THE BYLAWS OF THE ASSOCIATION OF PROGRAM DIRECTORS IN RADIOLOGY AND SUCH CHANGES AND AMENDMENTS AS MAY HERE AFTER BE PROPERLY ADOPTED.

Signature of applicant _____ Date _____

The above applicant is associated with the teaching program at this institution as indicated above

Signature of Department Chair _____ Name of Department Chair (Please Type or Print) _____ Date _____

PAYMENT INFORMATION (in US funds drawn on a US bank): **Check enclosed** **MasterCard** **Visa**

By sending your check to us, you authorize APDR to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

Account Number: _____ Exp Date _____

Name on Card: _____ Signature: _____
(Print name)

Please return Application to: Membership Services, APDR, 820 Jorie Boulevard, Oak Brook, IL 60523. **Completed form must be accompanied by a \$50 application fee and the first year's dues payment of \$190 for a total payment of \$240 made payable to the APDR.** Thank you.