American Society of Neuroradiology
820 Jorie Blvd., Suite 300 Oakbrook, IL 60523
Membership Department
1-630-574-0220 Extension 100

ASNR
American Society of Neuroradiology

Program Verification Form

Please complete this form and have it signed by your Program Director or Coordinator. *All fields are required to be filled in. Please email completed form to membership@asnr.org.

Name & Institution

The following individual is currently enrolled in **medical school**, radiology **residency** program, **PhD** or **postdoctoral** program, or a neuroradiology or related subspecialty **fellowship** program.

Full Name (please print): ____

Academic Degree (MD, DO, MBBS, etc.): ____

Name of Institution: ____

Program Type: (please check one)

Medical School

Internship (please specify): ____

Residency (indicate residency type)
Diagnostic Radiology   Other (please specify): ______________________________

Fellowship (indicate fellowship program type)
Neuroradiology   Other (please specify): ______________________________

Graduate Studies Program (PhD), area of study:______________________________

Postdoctoral Fellowship, area of study: ______________________________

Program Dates

Begin Date (MMDDYY): ____/____/______

Completion Date (MMDDYY): ____/____/______

Verification

Program Director or Program Coordinator must verify that the individual is currently enrolled in the program by signing below.

____
Printed name of director or coordinator of current program

X ____
Signature of Director or Coordinator of current program