RADIOLOGICAL SOCIETY OF NORTH AMERICA
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RSNA® Radiological Society of North America

RADIOLOGICAL SOCIETY OF NORTH AMERICA
PROGRAM VERIFICATION

Please upload your completed verification form under Uploaded Files on your My Account page.

NAME & INSTITUTION

The following individual is currently enrolled in medical school or formal radiologic training program:

Full Name *(print)*: _____

Academic degree(s):_____

Name of institution: _____

PROGRAM TYPE

☐ Medical School
☐ Internship
☐ Residency (indicate residency program type)
  ☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology
☐ Fellowship (indicate fellowship program type)
  ☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology

☐ Graduate Studies Program, area of study: _____

☐ Research Fellowship, area of study: _____

PROGRAM DATES

Begin date: [month/day/year] ____ /____ /____

Anticipated completion date: [month/day/year] ____ /____ /____

VERIFICATION

Program director or coordinator must verify that individual is enrolled in medical school or formal radiologic training program by printing and signing below:

_____
Printed name of director or coordinator of current program

X_____
Signature of director or coordinator of current program

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