



ACNM

Membership Application

MEMBER CATEGORIES

- Full - \$325
- Emeritus - \$70
 - Add print journal - \$99
- Associate - \$162.50
- Opt Out: I would like to opt-out of receiving print copies of the *Clinical Nuclear Medicine (CNM)* journal (online access will not be affected).

- Affiliate - \$70
- Corporate - \$250
- Honorary - \$70

IN-TRAINING

- Resident* - FREE
 - Add online journal - \$25
 - Add print/online journal - \$99

* Resident members must provide proof of residency by submitting the attached program director form signed by your program director.

e-Anatomy: Interactive Atlas of Human Anatomy

ACNM members can now subscribe to a new IMAIOS e-Anatomy Program for only \$21 annually. Explore over 5,400 anatomic structures and more than 375,000 translated medical labels. Images in: CT, MRI, Radiographs, Anatomic diagrams and nuclear images.

- Add annual e-Anatomy Atlas Subscription - \$21

MEMBER INFORMATION (Please supply Institutional and Home Address Information)

First Name: _____ Middle Initial: _____ Last Name: _____

Male Female Birth date: ___/___/___ Academic degree(s): _____

**If Resident, please complete: Date of Graduation: _____ Fellowship Completion Date: _____

Preferred mailing address: Home Work

HOME ADDRESS: Street Address/Apt.: _____ City: _____

State: _____ Country: _____ Province: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

WORK ADDRESS: Institution/Company: _____ Division: _____

Department: _____ Present Position (Title): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Business Phone: _____ Fax: _____ E-mail: _____

PROFESSIONAL INFORMATION:

Medical School/College	Location	Degree	Year

Board Certification(s): _____

(ABMS approved) Name of specialty/subspecialty board Year: _____

Other certification: _____

Name of certifying body Year: _____

Signature of applicant: _____ Date: ___/___/___

PAYMENT INFORMATION

I am submitting a check made payable to ACNM, Check #: _____

I hereby authorize ACNM to charge my credit card Amex Visa MasterCard Total Amount: \$_____

Credit Card #: _____ Expiration Date: _____

Cardholder Signature: _____

You may copy this application and send it with your check or credit card information to:

American College of Nuclear Medicine ■ P.O. Box 37512, Baltimore, MD 21279-3512 or fax to 703-667-5134 ■ For more information you may call, 703-326-1186



Program Director Certification

(for resident membership applications only)

I hereby certify that _____, is a current resident
(Print Name of Individual)

enrolled in the _____ program at _____,
(Name of Program) (Name of University)

with an expected graduation date of _____.
(Month/Day/Year)

Signature: _____ Date: _____

Name (Please Print): _____

Title: _____

What current degree programs are you enrolled in?

- | | | |
|-----------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> AA | <input type="checkbox"/> Doctorate | <input type="checkbox"/> Certificate |
| <input type="checkbox"/> BS | <input type="checkbox"/> MS | <input type="checkbox"/> Other _____ |

Please return to the ACNM Membership Department at memberinfo@acnmonline.org or by fax to 703.667.5134.