ACNM Membership Application

MEMBER CATEGORIES

- ❑ Full - $325
- ❑ Emeritus - $70
  - ❑ Add print journal - $99
- ❑ Associate - $162.50
- ❑ Affiliate - $70
- ❑ Corporate - $250
- ❑ Honorary - $70

❑ 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).

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 $29 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 - $29

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