820 Jorie Blvd, Oak Brook, IL 60523
PHONE: 630-368-3737
FAX: 630-571-2198

2015-2016 International Membership Application

(Revised 5/2015)

First Name_____ Middle_____

Last Name/Family Name:_____ Degree(s) to be published:_____

Position: ☐Program Director ☐Co-Director ☐Assistant/Associate ☐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*):_____

Approved for _____(number of res./fellows)

Institution/Hospital: _____

Program Address: _____ Dept:_____

City: _____ State or Province: _____ Zip/Postal Code:_____

Country: _____

Phone Number:_____ Fax Number: _____ E-mail_____

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.

Card Number

Expiration Date (MM/YY)

_____ _____
Signature Name as it appears on card

Please return Application to: APDR Membership Office, 820 Jorie Boulevard, Oak Brook, IL 60523, USA. **Completed form must be accompanied by a $50 application fee and the first year's dues payment of $250 for a total payment of $300 made payable to the APDR.** Thank you.