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APPLICANTS MUST COMPLETE ALL FIELDS OF THE APPLICATION. PLEASE ENTER "N/A" IN NON-APPLICABLE FIELDS.

Full name as you would like it to appear on your Membership Certificate:

First	Middle	Last	Degree (MD, etc.)

- Application for:**
- Full Member (MDs, Dos, PhDs, etc.)
 - Affiliate Member (Fellows/Residents-in-Training)*
 * **Applicants must provide training completion date and director information below**
 - Technologist Member**
 ** **Applicants must currently practice as technologists and provide certification and/or training information**
 - Associate Member (Nurses, Industry, etc.)

Preferred Mailing Address: Work Home

Please include both addresses and a phone number. Please note that ASNC does not sell phone numbers or e-mail addresses.

Company Name/Department _____

Street Address _____

City _____ State _____ Country _____ Postal/Zip Code _____

Phone Number (with Country Code) _____ Fax _____ E-Mail _____

Home Address _____

City _____ State _____ Country _____ Postal/Zip Code _____

Gender: Male Female Date of Birth: _____ Address to list in Membership Directory: Home Work

All applicants must answer the following four questions. Please check "N/A" if the question is not applicable.*

1. Has your medical license ever been suspended, terminated, or reduced in scope? Yes No N/A
2. Have you ever had hospital staff privileges denied, reduced in scope, or rescinded? Yes No N/A
3. Have you ever had disciplinary action taken against you at any time by a medical society, academic institution, or government agency? Yes No
4. Have you ever been convicted of or plead guilty to a felony or other serious crime? Yes No

* If you answered "yes" to any of the above questions, please append additional sheet(s) with a detailed explanation.

Professional Activity Level (check all that apply):

1. Full-Time Part-Time
2. Private Academic Industry

Principal Role in Nuclear Cardiology:

- Physician Scientist Technologist
- R&D Marketing Computer Specialist
- Other: _____

Principal Type of Practice:

- Cardiology Radiology Nuclear Cardiology Nuclear Medicine Other: _____

Training Program Institution/Department: _____

Expected Completion Date: ____ / ____ / ____ **Name of Training Program Director:** _____

