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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.)

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.

Training Program Institution/Department: \_\_\_\_\_  
 Expected Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Training Program Director: \_\_\_\_\_

Work 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.\**

- Has your medical license ever been suspended, terminated, or reduced in scope? .....  Yes  No  N/A
- Have you ever had hospital staff privileges denied, reduced in scope, or rescinded? .....  Yes  No  N/A
- Have you ever had disciplinary action taken against you at any time by a medical society, academic institution, or government agency? .....  Yes  No
- 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.**

**Principal Type of Practice:**

Cardiology  Radiology  Nuclear Cardiology  Nuclear Medicine  Other: \_\_\_\_\_

Affiliate Membership Application (continued)

Please note that the following is required for all Affiliate applicants.

**Education:\*** (Please list highest degree.)

Name of Institution	City	State	Country	Date	Degree	Subject(s)

**Postgraduate Training:\***

**1. Intern/Resident/Other**

Name <u>and</u> Location of Institution	Area of Specialization	Completion Dates	Degree

**2. Fellow**

Name <u>and</u> Location of Institution	Area of Specialization	Completion Dates	Degree

**3. Nuclear Cardiology**

Name <u>and</u> Location of Institution	Area of Specialization	Completion Dates	Degree

**Certification:\***

Name of Primary Certification Board (eg, ABIM, NMTCB, etc.)	Date of Initial Certification

Name of Sub-Specialty Certification Board (eg, ABIM: Cardiovascular Diseases, etc.)	Date of Initial Certification

Name of Sub-Specialty Certification Board (eg, CBNC, etc.)	Date of Initial Certification

**Medical Society Memberships:\*** \_\_\_\_\_

\* Append additional sheets if needed. To expedite the process of your application, we recommend attaching your curriculum vitae.

**I hereby certify that all information on this application and any attached documents is accurate, and I agree that the American Society of Nuclear Cardiology may verify any of the above data. I agree to conform to the Bylaws of the Society.**

**X** \_\_\_\_\_  
 Personal signature of applicant Date

Please note that applications will not be processed without signature or completion of required information fields.