Application For: ASNC Physician Members (MD, DO, PhD, etc.)

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 ASNC Membership Certificate)

FIRST NAME                                                      MIDDLE NAME OR INITIAL  LAST NAME

PROFESSIONAL DEGREES: (Please check all applicable degrees) □MD  □PhD  □DO  □MB BS  □MB ChB  □Other ____________


PREFERRED MAILING ADDRESS: □Work    □Home (Check one) Please note that ASNC does not sell phone numbers or e-mail addresses.

ADDRESS TO LIST IN MEMBERSHIP DIRECTORY: □WORK □HOME □NONE (Check one)

COMPANY NAME / DEPARTMENT

WORK STREET ADDRESS

CITY                                    STATE                                    COUNTRY                                        ZIP/POSTAL CODE

PHONE                                    FAX                                    E-MAIL (required)

HOME STREET ADDRESS

CITY                                    STATE                                    COUNTRY                                        ZIP/POSTAL CODE

GENDER: □MALE  □FEMALE  DATE OF BIRTH: ________/_______/_______

PROFESSIONAL WORK SETTING:
□Solo Practice    □Group Practice    □Hospital    □Academic    □Industry    □Other: ________________

OCCUPATION:
□Physician    □Technologist    □Scientist    □Research    □Industry    □Nurse    □PA  □NP

PRIMARY MEDICAL SPECIALTY: (Check one)
□Nuclear Cardiology □General Cardiology □Nuclear Medicine □Echocardiography □Radiology □CT Cardiology □MR Cardiology □Other: ________________

SECONDARY MEDICAL SPECIALTY: (Check all that apply)
□Nuclear Cardiology □General Cardiology □Nuclear Medicine □Echocardiography □Radiology □CT Cardiology □MR Cardiology □Other: ________________

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
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 Have you ever had hospital staff privileges denied, reduced in scope or rescinded □Yes □No □N/A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 detailed explanation.
EDUCATION: (Required for ALL applicants. Please list original MD/DO/MB BS, etc. degree.)

_____________________________________________________________ _______________________________________________________________
NAME OF INSTITUTION            CITY                 STATE          COUNTRY  GRADUATION DATE         DEGREE  SUBJECT(S)

POSTGRADUATE TRAINING:
1. Intern/Resident/Other: [If you are a CURRENT Resident, please list expected completion date.]

NAME OF INSTITUTION            CITY                 STATE          COUNTRY  AREA OF SPECIALIZATION (e.g., INTERNAL MEDICINE)  COMPLETION DATE

NAME OF INSTITUTION            CITY                 STATE          COUNTRY  AREA OF SPECIALIZATION (e.g. CARDIOLOGY)  COMPLETION DATE

2. Fellow: [If you are a CURRENT Fellow, please list expected completion date.]

NAME OF INSTITUTION            CITY                 STATE          COUNTRY  AREA OF SPECIALIZATION (e.g., NUCLEAR CARDIOLOGY)  COMPLETION DATE

3. Additional Training:

NAME OF INSTITUTION            CITY                 STATE          COUNTRY  AREA OF SPECIALIZATION (e.g., NUCLEAR CARDIOLOGY)  COMPLETION DATE

CERTIFICATION(S):

NAME OF PRIMARY CERTIFICATION BOARD DATE OF INITIAL CERTIFICATION

NAME OF SUB-SPECIALTY CERTIFICATION BOARD DATE OF INITIAL CERTIFICATION

NAME OF SUB-SPECIALTY CERTIFICATION BOARD DATE OF INITIAL CERTIFICATION

MEDICAL SOCIETY MEMBERSHIPS: (e.g., ACC, AMA, ASE, SCCT, EANM, ESC, SNM, etc.)

Medical License Number: ___________________________ License to Practice in State: ___________________________

Do you currently have an individual subscription to the Journal of Nuclear Cardiology (JNC)? □ Yes □ No

PAYMENT INFORMATION:

☐ Full Domestic Physician Member, US & Canada ($275)  ☐ Full International Physician Member ($200) [Includes paper JNC]
       ☐ Early Career Physician 1st yr.($75)  ☐ Early Career Physician 2nd & 3rd yr.($150)
       ☐ Fellow-in-Training Member (Complimentary)

Please charge my: ☐ Visa  ☐ MasterCard  ☐ American Express

Check Enclosed (in USD only): ☐ Personal #: __________________  ☐ Company #: __________________

CARD NUMBER  EXPIRATION DATE  SECURITY CODE (3/4 DIGIT CODE)

SIGNATURE  PRINTED NAME ON CARD

Note: Please check the Statement of Intent below to activate your membership.

☐ I hereby certify that all information on this application and any attached documents are accurate, and 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. I understand that the submission of false information or statements in this application may be grounds for future disciplinary action against my membership in the Society, including but not limited to revocation or suspension.

PERSONAL SIGNATURE OF APPLICANT  DATE

*Please note that applications will not be processed without agreement to the statement above, signature and completion of the application.