



PACIFIC NORTHWEST RADIOLOGICAL SOCIETY

ESTABLISHED IN 1946

Application For Membership

Name: _____

Practice Name: _____

Practice Address: _____

Practice Phone: (_____) _____ Practice Fax: (_____) _____

Home Address: _____

Home Phone: (_____) _____ E-Mail Address: _____

EDUCATION: (School Name & Years Attended)

Medical School: _____

Residency: _____

Fellowship: _____

Present Radiology Practice Type: _____

Certification: FRCP Year - _____ ABR Year - _____ Board Eligible

Professional Society Memberships: _____

I have completed my residency within the last three years and I understand that I am eligible to receive free registration to a PNWRS Annual Meeting within the next three years.

MEMBERSHIP DUES: \$200.00 (U.S. Funds) for a Three-Year Membership

- Enclosed is my check for payment
- Please charge my Visa or MasterCard

Name: _____

CC#: _____ Exp. Date: _____

Signature: _____

MAIL TO: PNWRS
2033 Sixth Ave., Suite 1100
Seattle, WA 98121

OR FAX TO: 206-441-5863

QUESTIONS: Contact the PNWRS at (206) 956-3643, or at JAL@wsma.org.