

# ISMRRM Application for Membership

Please send application and all materials to ISMRM:

P.O. Box 45690 • San Francisco, CA • 94145-0690, USA • Phone: +1 510 841 1899 • Fax: +1 510 841 2340 • E-mail: info@ismrm.org • Web site: www.ismrm.org

Name: \_\_\_\_\_ Gender:  Male  Female  
Family Name First/Given Name Middle Name  
 Date of Birth: \_\_\_\_\_

How did you become aware of ISMRM membership?  Through an associate  saw ad in journal  attended annual meeting  received brochure/postcard in mail

Honorific:	Date of Degree	Professional Classification	Primary field of endeavor:		Professional affiliations (check as many as apply)
			BASIC SCIENCE	CLINICAL SCIENCE	
<input type="checkbox"/> M.D.		<input type="checkbox"/> Basic Scientist	<input type="checkbox"/> Biochemistry	<input type="checkbox"/> Cardiology	<input type="checkbox"/> AAN <input type="checkbox"/> AAPM <input type="checkbox"/> ACR
<input type="checkbox"/> M.D. Candidate		<input type="checkbox"/> Clinical Scientist	<input type="checkbox"/> Biophysics	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> ASNR <input type="checkbox"/> IEEE <input type="checkbox"/> ESMRMB
<input type="checkbox"/> Ph.D.		<input type="checkbox"/> Educator	<input type="checkbox"/> Chemistry	<input type="checkbox"/> Molecular Imaging	<input type="checkbox"/> JSMRM <input type="checkbox"/> NASCI <input type="checkbox"/> RSNA
<input type="checkbox"/> Ph.D. Candidate		<input type="checkbox"/> Industrial Management	<input type="checkbox"/> Drug Development	<input type="checkbox"/> Neurology	<input type="checkbox"/> SCMR <input type="checkbox"/> SMI <input type="checkbox"/> SNM
<input type="checkbox"/> Professor		<input type="checkbox"/> Radiologist	<input type="checkbox"/> Engineering	<input type="checkbox"/> Oncology	ISMRRM makes its member list available to a few, carefully screened companies. If you DO NOT wish to be included, check here: <input type="checkbox"/>
<input type="checkbox"/> RT		<input type="checkbox"/> Radiology Support Personnel	<input type="checkbox"/> Mathematics	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	<input type="checkbox"/> Molecular Imaging	<input type="checkbox"/> Radiology	
<b>PLEASE TELL US WHO REFERRED YOU TO ISMRM</b>			<input type="checkbox"/> Oncology	<input type="checkbox"/> Surgery	
ISMRRM rewards existing members who recruit three new members (one M.D., one Ph.D., and one student) in 2010. The member who referred you to ISMRM is eligible for this reward. Please enter their name on the line below.			<input type="checkbox"/> Physics	<input type="checkbox"/> Other: _____	
I was referred by: _____			<input type="checkbox"/> Physiology	Send annual renewal notice to my: <input type="checkbox"/> Institution <input type="checkbox"/> Home	
			<input type="checkbox"/> Other: _____	Send journals and correspondence to my: <input type="checkbox"/> Institution <input type="checkbox"/> Home	

CONTACT INFORMATION	Institution Contact Information	Institution Name:	Home Contact Information	
	Street Address:		Street Address:	
	City & State/Province:		City & State/Province:	
	Country & Postal Code:		Country & Postal Code:	
	Telephone:		Telephone:	
	Fax:		Fax:	
	Email:		Email:	

STUDY GROUPS	STUDY GROUPS	
	<input type="checkbox"/> Cardiac MR	<input type="checkbox"/> MR Engineering
	<input type="checkbox"/> Current Issues in Brain Function	<input type="checkbox"/> MR Flow & Motion Quantitation
	<input type="checkbox"/> Diffusion & Perfusion	<input type="checkbox"/> MR in Drug Research
	<input type="checkbox"/> Dynamic NMR Spectroscopy	<input type="checkbox"/> MR of Cancer
	<input type="checkbox"/> High Field Systems & Applications	<input type="checkbox"/> MR Safety
	<input type="checkbox"/> Hyperpolarized Media MR	<input type="checkbox"/> Musculoskeletal MR
	<input type="checkbox"/> Interventional MR	<input type="checkbox"/> Psychiatric MR Spectroscopy & Imaging
	<input type="checkbox"/> Molecular & Cellular Imaging	<input type="checkbox"/> Susceptibility Weighted Imaging
	<input type="checkbox"/> Motion Correction	<input type="checkbox"/> White Matter

2010 MEMBERSHIP DUES	2010 MEMBERSHIP DUES	
	Membership is effective from 1 January–31 December of the year the application is approved.) Dues remittance must accompany the membership application submission.	
	<i>Please choose one:</i>	
	<input type="checkbox"/> Full Member with one journal* ( <input type="checkbox"/> JMRI or <input type="checkbox"/> MRM)	US \$280
	<input type="checkbox"/> Full Member with both JMRI and MRM journals*	US \$385
	<input type="checkbox"/> Student Member without journals	US \$30
	<i>Please choose one:</i>	
	<input type="checkbox"/> Student Member with one journal* ( <input type="checkbox"/> JMRI or <input type="checkbox"/> MRM)	US \$135
	<input type="checkbox"/> Student Member with both JMRI and MRM journals*	US \$240
	<i>Please choose one:</i>	
<input type="checkbox"/> Associate Member with one electronic-only journal ( <input type="checkbox"/> JMRI or <input type="checkbox"/> MRM)	US \$30	
* I prefer to receive my journal(s): <input type="checkbox"/> in print form & electronic form <input type="checkbox"/> in electronic form only		
For full descriptions of membership levels, visit: <a href="http://www.ismrm.org/membership-journals/membership/">www.ismrm.org/membership-journals/membership/</a>		

If paying by check, make payable to ISMRM. To pay by credit card, please complete below:

Visa  MasterCard  AMEX

Card holder's Name: \_\_\_\_\_  
 Credit Card # \_\_\_\_\_ (Required)  
 Expiration Date \_\_\_\_\_ 3- or 4-digit Security Code \_\_\_\_\_ (Required)  
 Cardholder Signature \_\_\_\_\_ (Required)  
 Billing Street Address \_\_\_\_\_ Billing Zip/Postal Code \_\_\_\_\_ (Required)

**Calculate your membership fees here. All fees must be in US Dollars**

Study Group Dues: (No charge for Students or Associates)  
 Number of study groups \_\_\_\_ x US \$20.00 = \_\_\_\_\_  
 2010 Membership Dues: \_\_\_\_\_  
 Total amount enclosed US \$ \_\_\_\_\_

Thank you for your application. Please review and note:

**ALL APPLICANTS MUST SUBMIT:**

- Membership Dues
- Completed application
- One (1) copy of current CV
- Application with sponsor Signature

**STUDENT APPLICANTS MUST ALSO SUBMIT:**

- Letter of student verification

**ASSOCIATE MEMBER APPLICANTS MUST ALSO SUBMIT:**

- Income Verification form (Please request from ISMRM)

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sponsor Signature: \_\_\_\_\_

Sponsor Name (please print): \_\_\_\_\_

I do not know a Full Member of the Society