INCOME VERIFICATION FORM

I, _____ (**supervisor full name**), certify that the annual income (***salary & bonus***) of _____ (**applicant full name**) is less than the equivalent of **US$10,000.00** as required for Associate Membership within the International Society for Magnetic Resonance in Medicine.

Department Head/Supervisor information (*required*):

First/Last Name: _____

Affiliation: _____

Office Phone: _____

Office Email: _____

Department Head/Supervisor Signature: _____

Department Head/Supervisor Print Full Name: _____

Date: _____

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