



## APPLICATION FOR MEMBERSHIP

PLEASE TYPE OR PRINT  
AND RETURN TO THE SECRETARY OF THE LIRS

Date \_\_\_\_\_

I, the undersigned, hereby apply for membership in the **LONG ISLAND RADIOLOGICAL SOCIETY**, and if accepted, agree to support the by-laws of this Society.

The accompanying check is payment for dues for the year.  
If not accepted as a member the money is to be returned to me.

Type of membership:  Full  Associate  Resident  Other Specify: \_\_\_\_\_

Name in full \_\_\_\_\_

Mailing Address \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_

Office Address \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Office telephone number \_\_\_\_\_

Place and date of birth \_\_\_\_\_

Medical College and date of graduation \_\_\_\_\_

Residency and dates \_\_\_\_\_

Date and number of New York license \_\_\_\_\_

Past and present hospital appointments and affiliations: \_\_\_\_\_

HOSPITAL or UNIVERSITY	FROM	TO


Diplomate, American Board of Radiology in \_\_\_\_\_

Date of Certification \_\_\_\_\_

Membership in following County Medical Society \_\_\_\_\_

I am , am not  a member of the New York State Chapter of the American College of Radiology.

I hereby designate the following local society for voting purposes in the New York State Chapter of the ACR \_\_\_\_\_

Government service \_\_\_\_\_

Is practice limited to radiology? \_\_\_\_\_

Names of associates in practice \_\_\_\_\_

Publications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sponsored by 1. \_\_\_\_\_

2. \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Approved by Executive Committee \_\_\_\_\_

Application voted upon \_\_\_\_\_

Letter of notification sent \_\_\_\_\_