

The Society of Uroradiology



Application for Active Membership

*The information below will be printed in the Membership Directory.
Please print clearly to assure accuracy.*

Name _____ Degree _____

Institution _____

Address _____

City _____ State _____ Country _____ Postal Code _____

Phone _____ Fax _____

E-mail _____

Spouse _____

Medical School _____ Year Graduated _____

Residency Training: Dates of training _____

Specialty _____ Institution _____

Board Certification: _____ Yes _____ No

Certifying Body _____ Date of certification _____

Documentation of involvement in urinary tract imaging (division head, responsible for residency teaching, publications, etc.)

Are there residents at one or more of the hospitals where you practice? _____ Yes _____ No

Are there residents in your specialty at your institution? _____ Yes _____ No

Please attach a current Curriculum Vitae.

Please return this completed form to the SUR administrative office at the address below.

**The Society of Uroradiology
c/o International Meeting Managers, Inc.
4550 Post Oak Place, Suite 342
Houston, Texas 77027**