



1. Company Information

Company Name: _____
Headquarter Address: _____
Main Contact Name: _____
City: _____ State/Province: _____
Zip/Postal Code: _____ Country: _____
Telephone: _____ Fax: _____
Website: _____

2. Key Contacts:

Chairman/CEO: _____
Phone: _____ Email: _____
President : _____
Phone: _____ Email: _____
CFO/Treasurer: _____
Phone: _____ Email: _____
COO: _____
Phone: _____ Email: _____

3. Is your company:

- Wholly owned subsidiary of _____
- Business Unit of _____
- Division of _____
- Privately Held by _____

4. Number of Locations: _____ States Serviced: _____

5. Modalities Offered: _____

6. Number of Employees (Total Organization): _____
Number of Certified Radiologists: _____

7. Organization Certifications: _____

8. Other Affiliations/Advocacy Groups: _____

9. I agree to abide by the current bylaws and any revisions thereof:

I certify that the foregoing statements are true and complete to the best of my knowledge and belief, and understand that any willfully false statement is sufficient cause for rejection of this application or the termination of the membership.

Signature of Applicant Date

Please select billing Option Below.

Onetime Payment of \$8,995 _____

Monthly Payments of \$1,000 _____

In kind Donation _____