Association of Academic Radiology
PO Box 1488
Warrenville, IL 60555
Phone: 224-276-7534
AARAD.ORG

ASSOCIATION OF ACADEMIC RADIOLOGY

PROGRAM VERIFICATION

Email the completed verification form to info@aarad.org.

NAME & INSTITUTION

The following individual is currently enrolled in medical school or formal radiologic training program:

Full Name (print): _____

Academic degree(s): _____

Name of institution: _____

PROGRAM TYPE

☐Medical School
☐ Internship
☐ Residency (indicate residency program type)
☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology
☐ Fellowship (indicate fellowship program type)
☐ Diagnostic ☐ Interventional ☐ Nuclear Medicine ☐ Radiation Oncology

PROGRAM DATES

Begin date: [month/day/year] _____ /_____ /_____

Anticipated completion date: [month/day/year] _____ /_____ /_____

CHIEF RESIDENCY

☐ I am a chief resident.
Begin date: [month/day/year] _____ /_____ /_____

End date: [month/day/year] _____ /_____ /_____

VERIFICATION

Program director or coordinator must verify that individual is enrolled in medical school or formal radiologic training program by printing and signing below:

_____
Printed name of director or coordinator of current program

X _____
Signature of director or coordinator of current program