ISPTI
INTERNATIONAL SOCIETY OF PEDIATRIC THORACIC IMAGING
official.ispti@gmail.com

MEMBER DATA FORM

Please paste recent photo here

PERSONAL INFORMATION

Name (*Last, First, Middle Initial, Suffix if any*):
Birthday (*Month/Day*)**:**
e-Mail address:

AFFILIATION/S

University:
Address:
Hospital 1:
Address:
Hospital 2 (*optional*)**:**
Address:

POSITION/S

Academic Designation: (*e.g. Professor*)	
Profession: (*e.g. Pediatric Radiologist*)	
Current Position 1:	**Since** (*Year*)**:**
Current Position 2: (*Optional*)	**Since** (*Year*)**:**
Previous position/s held: (*Maximum of 3*)	**Years in service:**