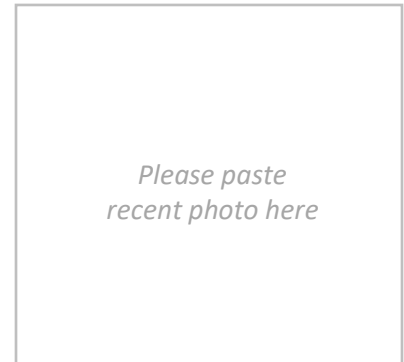




MEMBER DATA FORM



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:
