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Clinical Associate Membership Requirements
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APPLICATION FOR CLINICAL ASSOCIATE MEMBERSHIP

Please type or print legibly

Please refer to the Clinical Associate Membership Information sheet accompanying this application for full details.

Name

First

Middle

Last

Degree

ADDRESS INFORMATION — List both home and office addresses, and check your preferred mailing address.

I prefer that correspondence is sent to my:  ☐ Home  ☐ Office

OFFICE

Applicant's Title

Institution/Affiliation

Department

Address

City

State

Zip

Phone

Email

Sponsor

Name of Sponsor

Institution

Phone

Email

PLEASE INDICATE YOUR PROFESSION

☐ Nurse Practitioner (NP)  ☐ Physician Assistant (PA)  ☐ Radiologic Technologists (RT)  ☐ Radiology Practitioner Assistant (RPA)

☐ Registered Nurse (RN)  ☐ Other

MEDICAL OR GRADUATE EDUCATION

Institution

Degree

Date

I agree to abide by the Bylaws of the SNIS and any revisions thereof:

Applicant's Signature

Date