



AARI Membership Application

Please complete form and return with payment to:
AARI, C/O Vikram Dogra, MD
University of Rochester School of Medicine
Department of Imaging Sciences
601 Elmwood Ave., Box 648
Rochester, NY 14642

Name (First / Middle /Last): _____

Street Address: _____

City / State / Zip: _____

Phone: _____ H / O (circle one) Fax: _____

e-mail: _____

Medical School: _____ Year: _____

Subspecialty: _____

Academic: _____

Private Practice: _____

Hospital Affiliation: _____ Resident/Fellow (circle one) at: _____

Annual Dues (\$50) _____ Life (\$250) _____

Residents and fellow in training: no charge, but fill out the form and provide residency information below e-mail address.