

# Registration and Housing Form

Save time...book online at [RSNA.org/Register](http://RSNA.org/Register)

## STEP 1: CONTACT INFORMATION

RSNA/AAPM Member Number or Customer Number \_\_\_\_\_

Last Name / Family Name \_\_\_\_\_ Degree(s) \_\_\_\_\_

First Name \_\_\_\_\_

Title \_\_\_\_\_

Nickname on Badge \_\_\_\_\_

Institution / Office / Hospital \_\_\_\_\_

Address (Line 1) \_\_\_\_\_  Home  Office

Address (Line 2) \_\_\_\_\_

City / State / Zip \_\_\_\_\_ Country \_\_\_\_\_

E-mail Address \_\_\_\_\_

Telephone + Country & City Code, if applicable \_\_\_\_\_

Fax Number \_\_\_\_\_

Cellular Telephone and Provider Name (U.S. only, for Emergency Text Broadcasting purposes only) \_\_\_\_\_

Accompanying Spouse/Family Member(s) (Children under the age of 16 will not be admitted.) \_\_\_\_\_

## STEP 2: REGISTRATION CATEGORY

Registration Category/Code \_\_\_\_\_ (ie, 23A).  
Refer to page 45

Registration Categories 15, 18, and 23 must submit verification in order to be processed.

Categories 10, 11, 13, and 14 indicate a practice setting:  
 Academic  Private  Hospital Setting  Other

Category 13 Only – Are you in training?  
 Yes  No

## STEP 3: PRIMARY SPECIALTY

Circle one subspecialty code from the following:

Breast/Mammography . . . . BR  
 Cardiac Radiology . . . . . CR  
 Chest . . . . . CH  
 Computed Tomography . . . . CT  
 Diagnostic Radiology . . . . DR  
 Emergency Radiology . . . . ER  
 Gastrointestinal . . . . . GI  
 Genitourinary . . . . . GU  
 Head & Neck . . . . . HN  
 Health Policy & Practice . . . HP  
 Informatics . . . . . IF  
 Interventional . . . . . IR  
 Magnetic Resonance . . . . . MR  
 Molecular Imaging . . . . . MI  
 Musculoskeletal . . . . . MK  
 Neuroradiology . . . . . NR  
 Nuclear Medicine . . . . . NM  
 Oncologic Imaging . . . . . OI  
 Pediatric Radiology . . . . . PR  
 Radiation Physics . . . . . PH  
 Radiation Oncology . . . . . RO  
 Radiobiology . . . . . RB  
 Ultrasound . . . . . US  
 Vascular . . . . . VA  
 Other . . . . . OT  
 If other \_\_\_\_\_

## STEP 4: DEMOGRAPHICS

Continuing Education Certificate – check only one:

**Physician CME Certificate:**  
 • Are you Board Certified in North America? Y / N

**CE Certificate for ARRT**

**Non-Physician Certificate:**  
 • Physicians: do you require transfer of CME credit to CAMPEP? Y / N  
 • Are you ABR certified? Y / N

**I do not require a certificate**

**Age Range:**  
 under 25  25 – 34  35 – 44  45 – 54  
 55 – 64  65 and over

**Sex:**  Male  Female

This is my first RSNA Annual Meeting

Check here if, under the Americans with Disabilities Act, you require accommodations or services in order to attend. You will be contacted by RSNA.

## STEP 5: HOTEL RESERVATION Complete hotel selection or go to step 6. Refer to page 42.

Arrival Day / Date \_\_\_\_\_ Departure Day / Date \_\_\_\_\_

1st Choice: Hotel Number & Name \_\_\_\_\_ 2nd Choice: Hotel Number & Name \_\_\_\_\_ 3rd Choice: Hotel Number & Name \_\_\_\_\_

Single (1 bed)  Double (2 persons / 1 bed)  Twin (2 persons / 2 beds)  Suite  Smoking  Non-smoking

Person(s) sharing my room (Other than Spouse / Family Member listed in Step 1 above) \_\_\_\_\_

If my choices are unavailable, please book a room based on:  Rate \$ \_\_\_\_\_  Location  Other: \_\_\_\_\_  
 Room Rate Desired \_\_\_\_\_

I do not require a hotel reservation because:  I will reserve a room later.  I am staying at a local residence.  
 I have reservations at (hotel): \_\_\_\_\_  I am sharing a room reserved by: \_\_\_\_\_

Information used for emergency contact during the meeting

## STEP 6: PAYMENT INFORMATION

Registration rate (Refer to page 45) \$ \_\_\_\_\_

Hotel reservation deposit enclosed \$ 300.00  
 (\$300 deposit must accompany this form)

**Additional Fee Offerings (optional)**

SAT02: NIH Grantsmanship Workshop \$35 \$ \_\_\_\_\_

SAT03: Study Section Reviewers Workshop \$35 \$ \_\_\_\_\_

**Total payment enclosed** \$ \_\_\_\_\_

Check # \_\_\_\_\_  American Express  Discover  MasterCard  Visa  
 (payable to **RSNA 2011** in U.S. funds, drawn on a U.S. bank)

Card number \_\_\_\_\_

Name as it appears on card \_\_\_\_\_ Expires Month / Year \_\_\_\_\_

Cardholder signature required I authorize RSNA to charge my credit card for the total amount listed. If my fees are totaled incorrectly, RSNA will make the necessary adjustments and charge my credit card accordingly.

Online  
[RSNA.org/Register](http://RSNA.org/Register)

Fax  
 1-800-521-6017  
 1-847-996-5401  
 (Outside U.S. & Canada)

Telephone  
 1-800-650-7018  
 1-847-996-5876  
 (Outside U.S. & Canada)

Mail  
 RSNA 2011/Experient  
 568 Atrium Dr  
 Vernon Hills, IL 60061-1731 USA

Email questions to:  
[rsna@experient-inc.com](mailto:rsna@experient-inc.com)

