

# Oregon Society of Radiologic Technologists

Application for Membership



## PLEASE PRINT CLEARLY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Professional Credentials \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Fax Number \_\_\_\_\_ Internet Address \_\_\_\_\_

### ► Please check ONE of the following member categories ◀

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>Voting Member ~ \$45</b> <ul style="list-style-type: none"><li>• Certified by ARRT or it's equivalent and holding an unrestricted license under state statute</li><li>• May vote and hold office in Society</li><li>• Life members</li></ul> | <input type="checkbox"/> <b>Non Voting Member ~ \$45</b> <ul style="list-style-type: none"><li>• Members interested in promoting the purposes and functions of OSRT but do not meet the qualifications of voting members</li><li>• Limited permit holders, Honorary members, supporting members, &amp; retired members</li><li>• May not vote or hold office in Society</li></ul> | <input type="checkbox"/> <b>Student Member ~ \$20</b> <ul style="list-style-type: none"><li>• Members currently enrolled in an accredited Radiologic Science Program</li><li>• May not vote or hold office in Society</li></ul> |
|--|---|---|

Check this box if you claim your membership dues on your income tax

❖❖ **First time** membership applications received between January 1<sup>st</sup> and May 1<sup>st</sup> are eligible for the following rate: \$60.00. This will pay for the current membership year plus the following year. Please note: memberships expire yearly on June 30<sup>th</sup>. ❖❖

### License Status: mark one

- Oregon License # \_\_\_\_\_  
 ARRT certification # \_\_\_\_\_  
 ASRT Member # \_\_\_\_\_

### Certified in: check all that apply

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Radiography      | <input type="checkbox"/> Mammography           | <input type="checkbox"/> MRI               |
| <input type="checkbox"/> CT               | <input type="checkbox"/> QI/QA                 | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Diagnostic Sonography | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> CIT              | <input type="checkbox"/> Bone Densitometry     |  |

**OSRT  
MISSION STATEMENT**

Develop a dynamic membership promoting and facilitating world-class radiologic patient care through enhanced market awareness and effective legislation.

**Work Status** ~ place of employment ~  Hospital  Dr's Office  Clinic  Ed. Facility  Other \_\_\_\_\_

Help ensure the future of our profession by donating to the OSRT Scholarship Fund. Every dollar you contribute helps provide scholarship opportunities for students enrolled in accredited RT programs within Oregon. \$ \_\_\_\_\_

**To Charge:** VISA or MC number: \_\_\_\_\_ 3-Digit Security Code \_\_\_\_\_  
on back of card (**required**): \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Address on card if different from applicant: \_\_\_\_\_ Zip: \_\_\_\_\_

signature \_\_\_\_\_ date \_\_\_\_\_ \$ \_\_\_\_\_ amount enclosed \_\_\_\_\_

❖❖ Send completed application and check/charge info to ~ **OSRT: PO Box 7863, Salem, OR 97303** ❖❖

For office use only: Date received: \_\_\_\_\_ Amount: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Card \_\_\_ QB DB CH