



AOSR Individual Membership Application Form

*Please fill out this form, attach related documents and submit to the AOSR Office (office@aosr.kr).

** Please add attachments if space provided is insufficient for your entries

1. Applicant Individual Information		
Title	<input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Other _____	
First Name		
Middle name		
Last Name		
Nationality		
Institute Name/Department		
Institute / Department Address	Address:	
	City:	State/Province:
	Zip/Postal Code:	Country:
Contact Address (If different from institute/department address)	Address:	
	City:	State/Province:
	Zip/Postal Code:	Country:
E-mail Address		
Phone Number		
Affiliated Society (National / International)	(If applicable)	
Email Address of Affiliated Society	(If applicable)	

2. Professional Information		
Education Information	Medical/University School Name:	Country:
	Degree:	
	Year of Graduation:	
	(If applicable) Graduate/Post Graduate institute:	
	Degree:	
**Residency Training	Institution Name:	Country:
	Year of Completion:	
**Fellowship Training	Institution Name:	Country:
	Duration of Fellowship:	Year of Completion:
**Other Education(s)	Degree:	Year of Completion:
Specialty	Profession Specialty - Please choose that which applies (if there is more than one, indicate the primary specialty)	
	<input type="checkbox"/> Diagnostic Radiology	<input type="checkbox"/> Interventional Radiology <input type="checkbox"/> Radiation Oncology
	<input type="checkbox"/> Medical Sciences	<input type="checkbox"/> Nuclear Medicine
	<input type="checkbox"/> Others (specify): _____	
	Areas of Practice and/or Interest	
	<input type="checkbox"/> General Diagnostic Radiology	<input type="checkbox"/> Neuroradiology <input type="checkbox"/> Nuclear Medicine
	<input type="checkbox"/> Cardiac Imaging	<input type="checkbox"/> Breast Imaging <input type="checkbox"/> Pediatric Imaging
	<input type="checkbox"/> Chest Imaging	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Radiation Oncology
	<input type="checkbox"/> Emergency Radiology	<input type="checkbox"/> Interventional <input type="checkbox"/> Artificial Intelligence
	<input type="checkbox"/> Gastrointestinal Imaging	<input type="checkbox"/> Vascular <input type="checkbox"/> Theranostics
<input type="checkbox"/> Genitourinary Imaging	<input type="checkbox"/> Musculoskeletal Imaging	
<input type="checkbox"/> Others (specify): _____		

3. Attachments – Please submit the related documents with the application form	
Attachments	- CV with Photo - Copy of qualifications (medical, specialty training and others) - Any other relevant supporting documents