Saskatchewan Association of Medical Imaging Managers

(Use the Tab or arrow keys to navigate through the form – use the Space bar to check boxes)

Application for Membership / Information Update

Date: _____

Personal Information

Surname: _____ Given Name: _____

Address: _____

City / Town: _____ Province: _____

Home Phone: _____ Postal Code: _____

Professional Designation (e.g., RTR, RTT, RTNM, ACR, B.Sc., etc.) _____

Employment Information

Employer: _____

Job Title: _____

Address: _____

City / Town: _____ Province: _____

Work Phone: _____ Postal Code: _____

e-mail: _____ Fax #: _____

Check all that apply

Modality:

- ☐ Radiography
- ☐ Radiation Therapy
- ☐ Nuclear Medicine
- ☐ Ultrasound
- ☐ Magnetic Resonance Imaging
- ☐ Education
- ☐ Sales / Service
- ☐ Biomedical Engineering
- ☐ Health / Medical Physics

Other (please specify)

Employed by:

- ☐ Hospital
- ☐ Clinic
- ☐ Government
- ☐ Commercial Company

Other (please specify)

Management / Supervisory Area

Brief Description: _____

Signature: _____