Society for Pediatric Interventional Radiology

Program Verification of Member-in-Training

The following individual is currently enrolled in medical school or formal radiologic training program.

Full Name (print):_____

Academic Degree(s): _____

Name of Institution: _____

Please provide the information below for the current training program.

Program Type	**Program Start Date:** (month/day/year)	**Anticipated Completion date:** (month/day/year)
Medical School		
Residency in Radiology		
Fellowship (Diagnostic Radiology)		
Fellowship (Interventional Radiology)		

Verification

The program director or coordinator must verify that the individual named above is enrolled in a medical school or formal radiology training program by printing and signing below.

_____

Printed name of current program director or coordinator Title

_____

Signature of program director or coordinator of current program