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SOCIETY OF NUCLEAR MEDICINE

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(see reverse side for instructions)

First Name Dr, Mr, Mrs, Ms, Miss (CIRCLE ONE)	Middle Initial	Last Name J	r, Sr, I, II, III (circle one)		
Check Degree(s) Earned:	(please type or	r print clearly)			
MD PhD DO MA MS	BA	BS AA AS	S Other		
Indicate Board Certification(s): ABNM ABR					
	N) 🗆 ARRT(T) 🗌 ARRT(R) 🗌 Othe	ər		
Please choose ONLY ONE of the following categories of membership for which you wish to be considered. (Categories of member- ship are described on the front page of this application and should be reviewed carefully before your choice is made.) Full Associate Technologist Affiliate					
Please check ONE box for preferred mailing address	, but complete	e both columns for our fi	iles:		
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DIVISION		STREET ADDRESS		APT. NO.	
DEPARTMENT		СПТҮ	STATE/PROVINCE/COUNTRY	ZIP CODE	
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APPLICANT'S SIGNATURE	·····		DATE		

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Deadline: April 15, 1995

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a. 500 patients plus	2. Specify	2. No
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c. 200-299 patients		SNM Subscriber
d. 100-199 patients		1. Yes
2. Private Clinic	Reason for Inquiry	2. No
3. R&D Commercial	1. Immediate Purchase	
4. University	2. General Information	
5. Government	3. Budgeting Information	
6. Other		

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