

DO NOT WRITE IN THIS SPACE	
Approved:	Date Reference Requested:
Date Received	Registration No.

1-2010



Radiation Oncology Registration for Initial Certification

*This is the **ONLY** registration form you need if you are a resident applying for certification in radiation oncology. One form takes you through the entire examination process. This registration form should be submitted in the **PGY-2/R1** year (first year of residency). Do not file any subsequent registration forms unless the ABR instructs you to do so.*

Make 2 copies of this form. Use extra paper for additional data if necessary.

TYPE IN OR PRINT CLEARLY (IN INK) ALL INFORMATION

CONTACT INFORMATION

Any change in contact information must be reported to the ABR immediately.

Name: _____ Male Female
Last name First name Middle name

Address to which you want Board correspondence sent:

_____ Street Address

_____ City State Zip

Last 4 Digits of your Social Security Number (U.S. or Canadian) _____

Date of Birth: _____ Birthplace: _____
MM / DD / YY City State Country

Citizenship: _____
Country

Telephone Numbers: Office: _____ Fax: _____

Home: _____ Fax: _____

E-mail Address: _____

Medical Education

Medical School _____
Institution City State

Degree: _____ Year _____
Do NOT enter MD if you received an MB, BS, or other degree

Foreign Medical Graduates Only

If you are a foreign medical graduate, you must provide the following information:

Have you been screened by Educational Council for Foreign Medical Graduates (ECFMG)? Yes No
If yes, you must attach a copy of your certificate number or letter of notification. This is in addition to copies of your medical school degree and your internship certificate.

Post-Medical-School Training in U.S. or Canada

Clinical Training – Please enclose a copy of your internship certificate.

Institution	City, State	Began (MM / DD / YY)	Completed (MM / DD / YY)

Please detail your residency training in radiation oncology:

Institution	City and State	Began (MM / DD / YY)	Completed (MM / DD / YY)
a) _____			
b) _____			
c) _____			

Please list contact information for program directors pertinent to this registration.

Full Name Business Address Zip Code

- a) _____
- b) _____
- c) _____

Please name any other field of residency in which you trained: _____

Institution	City, State	Began (MM / DD / YY)	Completed (MM / DD / YY)

Other specialty board certification: Board _____ Date _____

List any medical practice, hospital staff and/or teaching appointments you have held since medical school.

Position/Field _____ Location _____ To/From _____

Position/Field _____ Location _____ To/From _____

Position/Field _____ Location _____ To/From _____

Position/Field _____ Location _____ To/From _____

PLEASE READ CAREFULLY BEFORE SIGNING

I, the undersigned, hereby register with the American Board of Radiology, Inc. for examination leading to certification, in accordance with and subject to stated rules and regulations. I agree to disqualification from examination or from issuance of a certificate of qualification in the event that any of the statements herein made by me are false, or if I violate any of the rules governing such examination.

I recognize the trustees of the American Board of Radiology (hereinafter, the Board) as the sole and only judge of my qualifications to receive and to retain a certificate issued by the Board and to have my name and demographic data included in any list or directory in which the names of diplomates of the specialty boards are published. I understand and agree that in the consideration of my registration, my moral, ethical and professional standing will be reviewed and assessed by the Board; that the Board may make inquiry of the persons named in my registration form and of such other persons as the Board deems appropriate with respect to my moral, ethical and professional standing; that if information is received which would adversely affect my registration, I will be so advised and given an opportunity to rebut such allegations, but I will not be advised as to the identity of any individual who has furnished adverse information concerning me; and that all statements and other information furnished to the Board in connection with such inquiry shall be confidential, and not subject to examination by me or by anyone acting on my behalf. I also pledge myself to the highest ethical standards in the practice of radiology.

I accept that admissibility to all certifying examinations is determined by the executive committee of the Board, and that each examination will be supervised by proctors who are responsible to the Board and empowered by the Board to ensure that the examination is conducted ethically and in accordance with the rules of the Board. I understand that I must bring government-issued photo identification to any examination that I attend. Such identification includes one of the following: state-issued driver's license, military ID, passport, state-issued ID. I further understand that no beeper, recorder, camera, PDA, cellular phone, or any device that has the capability to record pictures, text, or sound can be brought to the examination; and that I am not permitted to bring into the examination any notes, scratch paper, textbooks, calculators or other reference materials. I further understand that irregular behavior such as copying answers, sharing information, using notes, or otherwise giving or obtaining unauthorized information or aid—evidenced by observation, statistical analysis of answers, or otherwise—on any portion of the examination will be reported to the Board and will constitute grounds for the invalidation of my examination, and may lead to my being judged unacceptable for certification by the Board. I recognize that examination materials, examination questions, props for the oral examination, and questions on the oral examination are copyrighted as the sole property of the American Board of Radiology and must not be removed from the test area or reproduced, in whole or in part, and that any reproduction of copyrighted material is a federal offense.

In furtherance to my registration with the American Board of Radiology, I hereby request and authorize any hospital or medical organization of which I am a member, have been a member, or to which I have applied for membership, and any person who may have information which is deemed by the Board to be material to its evaluation of my registration, to provide such information to representatives of the Board upon their request. I agree that communication of any nature made to the Board regarding my registration may be made in confidence and shall not be made available to me under any circumstances. I hereby release from liability any hospital, medical staff, medical organization or person, and the Board and its representatives, from liability for acts performed in good faith and without malice in connection with the provision, collection, or evaluation of information or opinions, whether or not requested or solicited by the Board in connection with my registration. I understand and agree that as a registrant, I have the responsibility to supply the Board with information adequate for the Board's proper evaluation of my credentials. I further agree that I will not cause or attempt to cause any public disclosure of the contents of any registration form, including my own, or any proceedings of any committee's evaluation of such registration form, whether such disclosure is by operation of law or otherwise.

I waive and release and shall indemnify the Board and its directors, members, officers, committee members, employees, and agents from, against and with respect to any and all claims, losses, costs, expenses, damages, and judgments (including reasonable attorney's fees) alleged to have arisen from, out of, with respect to or in connection with any action which they, or any of them, take or fail to take as a result of or in connection with this registration, any examination conducted by the Board which I register to take or take, the grade or grades given me on an examination and, if applicable, the failure of the Board to issue me a certificate or qualification or the Board's revocation of any certificate or qualification previously issued to me.

To help analyze the effectiveness of my training program, I hereby authorize the American Board of Radiology to release to the director(s) of the program in which I am or was enrolled, and to the chair of the department of which the program is a part, the results of my performance on the examinations conducted by the American Board of Radiology.

Signature _____ Date _____

PLEASE NOTE:

1. You must submit 2 **signed** copies of this registration form.
2. Incomplete forms will **NOT** be accepted. The postmark affixed to the last item received to complete your registration must be on or before the deadline date.
3. Registration forms will not be accepted prior to July 1. The filing deadline for examination in any given year is **September 30** of the year preceding the exam. There is a nonrefundable fee for registration forms postmarked between Oct. 1 and Oct. 31. No registration forms will be accepted after Oct. 31 for examination in the following year.
4. For a listing of fees to be submitted with this form, please refer to our website: <http://www.theabr.org>. **If you are in a non-traditional residency program, your fee schedule may be different but you will ultimately be paying the same total fee as traditional residents. You will be billed as necessary.**
5. All payments must be in U.S. currency. Payment may be made by personal check, money order, Visa or MasterCard, payable to The American Board of Radiology. **If your payment is declined for any reason, there will be a \$100.00 processing fee.** If paying by Visa or MasterCard, please attach a completed Credit Card Form (following page).
6. Return completed applications along with required payment to:

THE AMERICAN BOARD OF RADIOLOGY
5441 E. WILLIAMS BLVD., SUITE 200
TUCSON, ARIZONA 85711



CREDIT CARD FORM

Though you are making 2 copies of the registration form, only 1 credit card form is required.

Candidate name: _____

Exact name that appears on credit card: _____

The following information must be as it applies to billing of the credit card.

Billing address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____

Visa MasterCard

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 CC#:

Expiration date: _____

Amount authorized: \$ _____

Signature of card holder: _____

If your payment is declined for any reason, there will be a \$100.00 processing fee.

For office use only	
ABR ID #: _____	Fee Code: _____