

**MEMBERSHIP APPLICATION FORM**  
**STUDENT MEMBER**

This category of membership is for:

Student members shall be members of the RANZCR who are either radiology registrars or undertaking training in interventional radiology.

IRSA Student Membership Join Fee (month of joining)			
Jan – Mar <input type="checkbox"/>	Apr – June <input type="checkbox"/>	Jul – Sept <input type="checkbox"/>	Oct – Dec <input type="checkbox"/>
\$155	\$135	\$115	\$105

Student membership will be charged at \$155.00 AUD (incl. GST) annually thereafter.

Please advise us once your status changes, and you are eligible for Active Fellow membership so we can update our records.

**Please email this completed form along with your current CV to IRSA Secretariat**  
[secretariat@irsa.com.au](mailto:secretariat@irsa.com.au)

Once your application has been reviewed and approved by the President or Secretary, you will be notified in writing and asked to make payment to finalise your membership with IRSA.

**YOUR DETAILS**

Title  Name

Qualifications (e.g. MBBS, FRANZCR, EBIR):

Preferred Mailing Address: WORK  HOME:

Principle place of work:

Email Address:

Preferred phone: Mob  Wk  Hm

Alternative phone: Mob  Wk  Hm

Area(s) of Interest in Interventional Radiology:

Academic/Research Interests

Last year my estimated time spent doing diagnostic work and interventional procedures was:

Diagnostic  %

Interventional  %

Signature

Date

Please have page 3 completed by your membership supporters.

**IRSA MEMBERSHIP SUPPORTERS DETAILS**

Candidates for student membership must be sponsored in writing by two active IRSA members in good standing who are familiar with and can substantiate the experience of the candidate.

**I support the application for IRSA membership for:**

(name of applicant)

Who is a member of the Royal Australian and New Zealand College of Radiologists and is either a radiology registrar or undertaking training in Interventional Radiology in Australasia.

**First Supporter**

Name

Signature

Qualifications (including EBIR):

Position title:

Practice/Hospital:

Preferred phone No:

**Second Supporter**

Name

Signature

Qualifications (including EBIR):

Position title:

Practice/Hospital:

Preferred phone No: