



Application for SCSRT Membership

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Employer: _____ Work Phone: _____

ARRT number: _____ SCRQSA number: _____ ASRT number: _____

****Please make sure to include copies of any current ARRT, SCRQSA, and/or ASRT cards***

MEMBERSHIP OPTIONS

**Active, Associate, Inactive, Supporting: \$35 (one year) or \$55 (two years)
Student: \$25 (membership expires at graduation or at loss of student status)**

____ ACTIVE: Active members shall have the right to vote and to hold office. Active members include those individuals certified by the ARRT, the NMTCB, or those individuals certified as Diagnostic Medical Sonographers. These individuals will be actively engaged in the healthcare field and maintain current membership in the ASRT.

____ ASSOCIATE: Associate members shall have all privileges and obligations of membership including the right to vote; however, excluding the right to hold office. Associate members shall be those individuals that meet all requirements of an active member except a current ASRT membership. Associate members include holders of the South Carolina Radiation Quality Standards Association (SCRQSA).

____ INACTIVE: Inactive members shall have all privileges and obligations of membership including the right to vote; however, excluding the right to hold office. Inactive members shall be those individuals who are no longer actively engaged in the field of radiation or imaging specialties and who applied for inactive status with the ARRT.

____ SUPPORTING: Supporting members shall be those individuals who are interested in promoting the purposes and functions of the SCSRT, but are not eligible for active, associate, inactive, or student membership.

____ STUDENT: Student members shall have all privileges and obligations of membership excluding the right to vote or to hold office. Student members are those individuals enrolled in an accredited educational program for radiography, radiation therapy, diagnostic medical sonography, or nuclear medicine technology.

School: _____ Anticipated Graduation Date: _____

Checks or money orders can be made payable to the SCSRT. There will be a \$40 returned check fee for insufficient funds.

****Please make sure to include copies of any current ARRT, SCRQSA, and/or ASRT cards***

Mail completed application, payment, and copies of certification cards to:
SCSRT
127 Boone Lane
Swansea, SC 29160

Signature: _____ Date : _____ Amount Enclosed: _____