The Kenya Association of Radiologists

APPLICATION FORM FOR ASSOCIATE MEMBERSHIP

Name _____

Postal Address _____

E-mail _____ Tel. _____

Academic qualifications

(Please attach a copy of your MBChB, or equivalent, degree)
Details of Radiology Residency Post

Publications

Recommended by (KAR Member at the Teaching Institution)

Training institution:

Name:

Signature:

Date:

(Use additional pages, if required.)

For Official Use Only.

Application Accepted/Rejected

Reason for Rejection:

Date:

Name of KAR official:

Signature: