**Please send this letter to ASAR Secretariat (****asar@secretariat.ne.jp****).**

1. **Personal Information:**

|  |  |  |
| --- | --- | --- |
| **First name** | **Middle name** | **Last name** |
| **Academic degrees/ Credentials to be published, 2 maximum** |

1. **Medical Education/University:**

|  |
| --- |
| **Medical School/ University name** |
| **Address** |
| **City** | **State or Province** | **Country** |
| **Degree/ Medical degree** | **Begin Date (Month/Year)** | **Completion Date (Month/ Year)** |

1. **Residency training Radiology:**

|  |
| --- |
| **Please indicate training Program(Select one)****□Diagnostic Radiology □Nuclear Medicine □Radiation Oncology** |
| **Institution Name:** | **Program Director’s Full name** |
| **City** | **State or Province** | **Country** |
| **Begin Date (Month/Year)** | **Anticipated Completion Date of fellowship (Month/ Year)** |

1. **Fellowship:**

|  |  |
| --- | --- |
| **Institution Name:** | **Program Director’s Full name** |
| **City** | **State or Province** | **Country** |
| **Begin Date (Month/Year)** | **Anticipated Completion Date of fellowship (Month/ Year)** |

1. **I apply for ASAR Educational lecture course as a resident.**

**I hereby certify that the foregoing statements are true.**

|  |  |
| --- | --- |
| **Applicant signature** | **Supervisor or Chairman of department’s signature** |
| **Date**  | **Date** |