



ISSRT ELECTRONIC POSTER APPLICATION FORM
(Please type)

Title of ePoster _____

Student Name _____

E-mail _____

Phone # _____

Home Address _____

Street City State Zip _____

ISSRT # _____

Radiologic Program (School) _____

School Address _____

Street City State Zip _____

I certify that I have read and understand the rules for the ePoster and agree to abide by them.

Student Signature _____ Date _____

I give my permission to have my name, picture, and eposter published on the ISSRT Web site.

Student Signature _____ Date _____

Applications and ePosters must be emailed by **March 1** to ISSRT.eposters@gmail.com You will receive a confirmation email by **March 3**.

***No Applications or ePosters will be accepted after MARCH 1.**