Australian Society of Medical Imaging and Radiation Therapy
The national professional organisation representing medical radiation practitioners
ABN 26 924 779 836

APPLICATION FOR
COMPUTED TOMOGRAPHY (CT) INTERMEDIATE LEVEL CERTIFICATION

CONTACT DETAILS					
MEMBERSHIP NO.					
SURNAME					
MAIDEN NAME					
GIVEN NAMES					
TITLE: MR/MRS/MS/MISS/OTHER					
DATE OF BIRTH					
RESIDENTIAL ADDRESS					
TOWN/SUBURB		STATE		POSTCODE	
TEL (HOME)		TEL (WORK)			
TEL (MOBILE)		EMAIL			

PART A THEORETICAL COMPONENT: CT INTERMEDIATE LEVEL CERTIFICATION EXAMINATION			
CT INTERMEDIATE LEVEL EXAMINATION TAKEN IN:	Please select...	YEAR	Please select...

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN CT

I, _____ , certify that I have performed over 500 CT examinations (as described on Page 2) within the 12-month period between the dates of _____ and _____ .

This period must have occurred within the 3 years prior to application submission.

Signed _____ Date _____

SUPERVISOR'S VERIFICATION

I, _____ , supervisor of the individual identified on the application verify that the individual has successfully completed over 500 CT examinations during the time period described above.

Signed _____ Date _____

Position _____ Name of Site _____

SUPERVISOR CONTACT DETAILS					
SUPERVISOR NAME					
SITE ADDRESS					
TOWN/SUBURB		STATE		POSTCODE	
TEL		EMAIL			

OFFICE USE ONLY			
CT INTERMEDIATE LEVEL CERTIFICATION NO.		DATE OPERATIVE	
SIGNED			
PAYMENT RECEIVED		RECEIPT NO.	
DATE MAILED			

DECLARATION – ASMIRT

This is to certify that _____

has satisfactorily completed all requirements and is recommended for the award of **INTERMEDIATE LEVEL CERTIFICATION IN CT.**

Signed _____ Date _____

Name _____ Position _____

EXAMINATIONS PERFORMED MUST INCLUDE 7 OF THE FOLLOWING 10 AREAS:

☐ 1. Brain	☐ 2. Neck
☐ 3. Chest (including HRCT)	☐ 4. Abdomen/Pelvis
☐ 5. Spine	☐ 6. Angiography
☐ 7. Extremity	☐ 8. Paediatric
☐ 9. Trauma	☐ 10. Interventional

*Performing the examination includes:

- Evaluation of request
- Patient preparation / positioning
- Protocol / parameter selection / scanning
- Filming (if done) and archiving
- Ensuring appropriate documentation

Applicants must be able to provide documentation to support exam numbers in the event of an audit.

PAYMENT AUTHORITY

COSTS	Please select...		
	Please select...	**Total Costs:**	$0.00
PAYMENT TYPE	☐ **Cheque** Please make payable to the ☐ **"Australian Society of Medical Imaging and Radiation Therapy"**	☐ **Credit Card** Please select the card below ☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX**	
CREDIT CARD NUMBER			
EXPIRY DATE		**CCV NO.** (LAST 3 DIGITS ON BACK OF CARD, OR LAST 4 DIGITS FOR AMEX)	
CARDHOLDER'S NAME			
CARDHOLDER'S SIGNATURE			

All prices are quoted in AUD dollars and include GST.

ALTERNATIVE PAYMENT METHOD

Pay by direct deposit to ASMIRT: BSB: 633000 A/C Number: 5325089

Quote Ref: Invoice # or email remittance advice to finance@asmirt.org

To submit via email **Click here** or click on File > Send

Alternatively, you can email the form to CT@asmirt.org

Registered Office:
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1 Queens Road
Melbourne Vic 3004
Australia

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Updated July 2023