



APPLICATION FOR **RENEWAL** OF MAGNETIC RESONANCE IMAGING (MRI) LEVEL 1 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			

MRI LEVEL 1 CERTIFICATION NO.		EXPIRY	
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PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN MRI

I, _____, certify that I have performed over 900 clinical MRI examinations (minimum 300 clinical MRI examinations per year) in the 3-year period between the dates _____ 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 900 clinical MRI 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

MRI LEVEL 1 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 **MRI LEVEL 1 CERTIFICATION**.

Signed _____ Date _____
Name _____ Position _____

PAYMENT AUTHORITY

COSTS			Total Costs:	
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.



Registered Office:

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