



APPLICATION FOR ADVANCED PRACTICE RE-CREDENTIALLING

This application form, when completed, is to be forwarded to the Chief Executive of the Society accompanied by the prescribed fee of \$68.00 (incl. GST)

APPLICANT'S DECLARATION

I, _____ (Family Name in Full) _____ (Given Names in Full)

Of _____ Street address _____ Suburb _____ State _____ Postal code _____

being a Financial Voting Member of the Australian Society of Medical Imaging and Radiation Therapy of at least 5 years standing hereby make application to submit documentation for advanced practice credentialling:-

_____ or Nuclear Medicine

MEMBERSHIP NO.		MEMBERSHIP DIPLOMA NO.	
DATE OF ADMISSION AS A VOTING MEMBER			
BRIEF PROFESSIONAL/EMPLOYMENT HISTORY			
PRESENT EMPLOYER			
BUSINESS ADDRESS			
TEL (HOME)		TEL (BUSINESS)	
TEL (MOBILE)		EMAIL	
Signed _____		Date _____	

OFFICE USE ONLY

The above details, in regards to membership, have been verified and the fee of \$67.00 received.

Chief Executive _____ Date _____

PAYMENT AUTHORITY

COST

\$68.00 (inc GST)

TOTAL AMOUNT (Including GST) \$

Cheque – Please make payable to “**Australian Society of Medical Imaging and Radiation Therapy**” (Australian Dollars Only)

CREDIT CARD (Please tick):

MASTERCARD

VISA

AMERICAN EXPRESS

EXPIRY DATE

CCV NO.

**(LAST 3 DIGITS ON BACK OF CARD,
OR LAST 4 DIGITS FOR AMEX)**

CARDHOLDER'S NAME

CARDHOLDER'S SIGNATURE

To submit via post,

Please print and send to
PO Box 16234, Collins Street West, VIC 8007

To submit via email,

or click on File > Send file. The form will then attach in your email client. Forms can be sent to execoff@asmirt.org

To submit via fax,

Please print and fax to 03 9416 0783

Registered Office:

Suite 1040, Level 10
1 Queens Road
Melbourne VIC 3004
Australia

All Correspondence to:

PO Box 16234
Collins Street West
VIC 8007
Australia

Contact Us:

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