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

APPLICATION FOR RENEWAL OF VASCULAR INTERVENTIONAL IMAGING (ANGIOGRAPHY) 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			

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN VASCULAR LEVEL 1

I, ____________________________________, certify that I have performed over 450 clinical vascular angiographic examinations (minimum 150 clinical vascular angiographic examinations per year must be completed every 12-months within the 3-year period) 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 450 clinical vascular angiographic examinations with a minimum of 150 completed every 12 months within this 3-year period).

Signed:____ Date:____________________________________

Position:____ Name of Site:_____________________________

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

OFFICE USE ONLY			
ANGIO CARDIAC LEVEL 1 CERTIFICATION		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 VASCULAR INTERVENTIONAL IMAGING (ANGIOGRAPHY) LEVEL 1 CERTIFICATION.**

Signed:_______________________________________ Date:______________________________

<table>
<tr><th colspan="4">PAYMENT AUTHORITY</th></tr>
<tr><td rowspan="2">COSTS</td><td colspan="3"></td></tr>
<tr><td></td><td>Total Costs:</td><td></td></tr>
<tr><td>PAYMENT TYPE</td><td>Cheque
Please make payable to the
“Australian Society of Medical Imaging and Radiation Therapy”</td><td colspan="2">Credit Card
Please select/circle the card below
VISA MASTERCARD AMEX</td></tr>
<tr><td>CREDIT CARD</td><td colspan="3"></td></tr>
<tr><td>EXPIRY DATE</td><td></td><td>CCV NO. (LAST 3 DIGITS ON BACK OF CARD, OR LAST 4 DIGITS FOR AMEX)</td><td></td></tr>
<tr><td>CARDHOLDER’S NAME</td><td colspan="3"></td></tr>
<tr><td>CARDHOLDER’S SIGNATURE</td><td colspan="3"></td></tr>
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