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

APPLICATION FOR RENEWAL
CERTIFICATE OF MAMMOGRAPHIC PRACTICE

(Fees current 01 July 2024 Through to 30 June 2025)

Please complete with reference to Guidelines for Issue of the

Certificate of Mammographic Practice available from www.asmirt.org/certification/#a5

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

APPLICANT'S DECLARATION

Evidence of the following may gain a renewal of the Certificate of Mammographic Practice (previously CCPM - please see 'CMP' renewal guidelines' document for more detail):

- Minimum of 10 hours/year over 3 years of Continuing Professional Development relevant to breast mammography (Please provide CPD activity list and breast mammography in the CMP CPD log pages. Routine QA is not acceptable)
- Clinical involvement in breast mammography for an average of 150 hours per year over the three-year period. (The applicant must have been employed in a clinical mammography setting for two of the past three years)
- Clinical competency relevant to their position / job attested to, in a statement letter by a qualified practitioner (ie. radiologist, supervisor/tutor radiographer in mammography) or direct line manager.

The following will not be accepted as evidence, so please do not send:

- Lists of identified patient/client/radiographer information
- Photocopied books or articles, pay slips or times sheets
- Unverified lists of activities.

DO NOT SEND ORIGINALS AS WE CANNOT GUARANTEE THEIR RETURN. **Required documentation attached** ☐ Yes ☐ No

Signed _____ Date _____

OFFICE USE ONLY					
CERTIFICATE NO				DATE OPERATIVE	
SIGNED				REVIEW DATE/S	
CERTIFICATE TO	Applicant ☐			Other ☐	
DATE MAILED	Surface/Air			Registered No.	
NOT GRANTED:	Ref No			Signed	

DECLARATION – OFFICE USE ONLY

This is to certify that _____ (Applicant's Name) has satisfactorily completed all requirements and is recommended for the award of **CERTIFICATE OF MAMMOGRAPHIC PRACTICE**

Date recommended _____

Signed _____ Date _____

Chairperson – BIRG (print) _____

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.

Clear Payment section

ALTERNATIVE PAYMENT METHOD

Pay by Direct Deposit to ASMIRT: BSB 633000, Acct #: 5679675

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

Click here

Registered Office:
Suite 1040 (Level 10)
1 Queens Road
Melbourne Vic 3004
Australia

All Correspondence to:
P.O. Box 16234
Collins Street West
Vic 8007
Australia

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F +61 3 9416 0783
W www.asmirt.org

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CMP CPD ACTIVITY LOG

NAME			
CONTACT NO.		**ASMIRT MEMBERSHIP NO.**	
EMAIL ADDRESS			

Please fill in this CPD log with mammography only activities when submitting your CMP renewal application.

DATE	BRIEF DESCRIPTION OF MAMMOGRAPHY RELATED ACTIVITY	Min (10 hours/year)
List date in sequential order per yr ie 3/2/21	***For example: reading journals/mammography articles***	5 hours
4/3/22	***For example: BreastScreen Mammography conference***	16 hours
5/5/23	***For example: mammography webinar***	1 hour
	Assessment Clinical visits and MDTM activities MUST be supported by a reflection.	

DATE	BRIEF DESCRIPTION OF ACTIVITY	HOURS/NUMBER

Registered Office:
Suite 1040-1044 (Level 10)
1 Queens Road
Melbourne Vic 3004
Australia

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Australia

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