Australian Society of Medical Imaging and Radiation Therapy

The national professional organisation representing medical radiation practitioners

ABN 26 924 779 836

APPLICATION FOR RENEWAL

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			

CT CERTIFICATION NO.		EXPIRY	

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN CT

I, ______________________________, certify that I have performed over 1000 CT examinations (as described on Page 2) within the 3-year period between the dates of ____________________ and ____________________.

This period must have occurred immediately 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 1000 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:

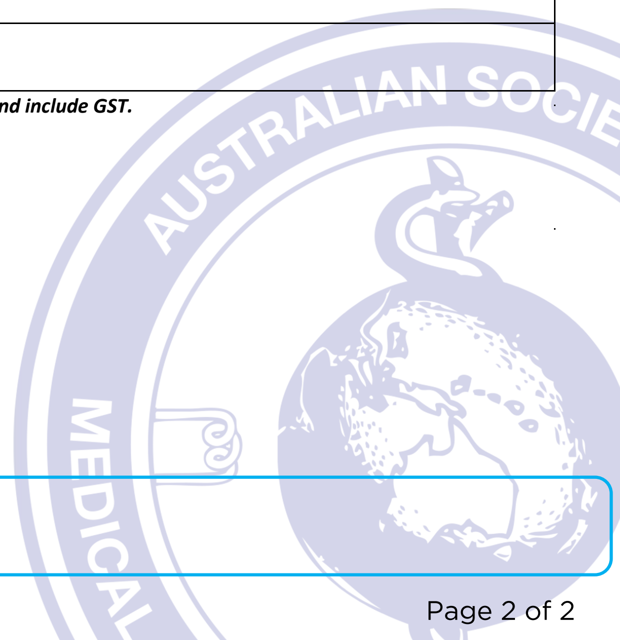
- Evaluation of request
- Patient preparation / positioning
- Protocol / parameter selection / scanning
- Filming (if done) and archiving
- Ensuring appropriate documentation

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

PAYMENT AUTHORITY

COSTS				
			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.



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