



APPLICATION FOR 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		

PART A THEORETICAL COMPONENT: MRI LEVEL 1 CERTIFICATION EXAMINATION			
MRI LEVEL 1 EXAMINATION TAKEN IN:		YEAR	

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN MRI	
I, _____, certify that I have performed over 300 clinical MRI examinations within the <u>12-</u> month period between the dates of _____ 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 300 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

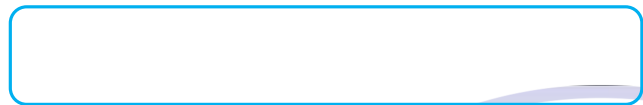
This is to certify that _____
 has satisfactorily completed all requirements and is recommended for the award of **MRI LEVEL 1 CERTIFICATION**.

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.



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