



## 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](http://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):			
<ul style="list-style-type: none"><li>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)</li><li>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)</li><li>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.</li></ul>			
<b>The following will not be accepted as evidence, so please do not send:</b>			
<ul style="list-style-type: none"><li>Lists of identified patient/client/radiographer information</li><li>Photocopied books or articles, pay slips or times sheets</li><li>Unverified lists of activities.</li></ul>			
DO NOT SEND ORIGINALS AS WE CANNOT GUARANTEE THEIR RETURN.	<b>Required documentation attached</b>	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	
<b>DECLARATION – OFFICE USE ONLY</b>			
This is to certify that (Applicant's Name) has satisfactorily completed all requirements and is recommended for the award of <b>CERTIFICATE OF MAMMOGRAPHIC PRACTICE</b>			
Date recommended			
Signed		Date	
Chairperson – BIRG (print)			

**PAYMENT AUTHORITY**

<b>COSTS</b>			
			<b>Total Costs:</b>
<b>PAYMENT TYPE</b>	<b>Cheque</b> Please make payable to the	<b>Credit Card</b> Please select the card below	
	<b>"Australian Society of Medical Imaging and Radiation Therapy"</b>	<b>VISA</b>	<b>MASTERCARD</b> <b>AMEX</b>
<b>CREDIT CARD NUMBER</b>			
<b>EXPIRY DATE</b>		<b>CCV NO.</b> (LAST 3 DIGITS ON BACK OF CARD, OR LAST 4 DIGITS FOR AMEX)	
<b>CARDHOLDER'S NAME</b>			
<b>CARDHOLDER'S SIGNATURE</b>			

*All prices are quoted in AUD dollars and include GST.*

**ALTERNATIVE PAYMENT METHOD**

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

Quote Ref: Invoice #, or email remittance advice to [finance@asmirt.org](mailto:finance@asmirt.org)

**OR email [cmp@asmirt.org](mailto:cmp@asmirt.org)**

**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

**Contact us:**

T +61 3 9419 3336  
F +61 3 9416 0783  
W [www.asmirt.org](http://www.asmirt.org)





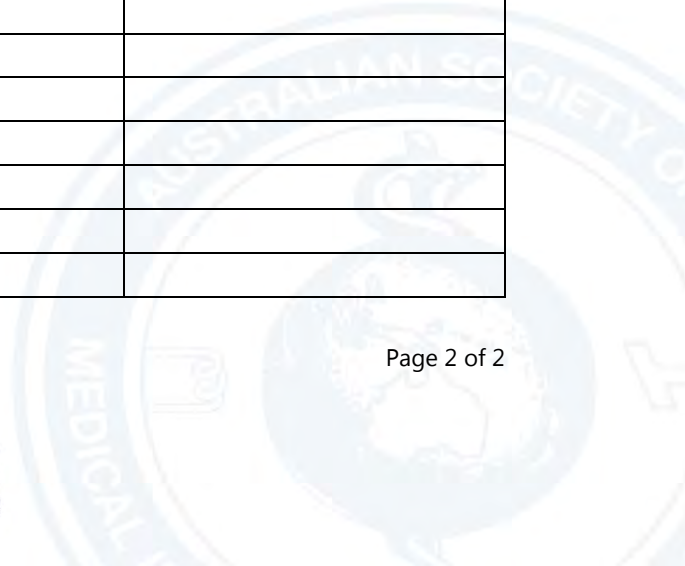


# Australian Society of Medical Imaging and Radiation Therapy

The national professional organisation representing medical radiation practitioners

ABN 26 924 779 836

DATE	BRIEF DESCRIPTION OF ACTIVITY	HOURS/NUMBER



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Melbourne Vic 3004  
Australia

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