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	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.

ALTERNATIVE PAYMENT METHOD

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

Quote Ref: Invoice #, or email remittance advice to finance@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:
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F +61 3 9416 0783
W www.asmirt.org

To submit via email **Click here** or click on File > Send Alternatively, you can email the form to CT@asmirt.org