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

# APPLICATION FOR
# RENEWAL OF 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 | | | |

| | | | |
|---|---|---|---|
| MRI LEVEL 1 CERTIFICATION NO. | | EXPIRY | |

## PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN MRI

I, _____ , certify that I have performed over 900 clinical MRI examinations (minimum 300 clinical MRI examinations per year) in the 3-year period between the dates _____ 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 900 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** | Please select... | | |
| | Please select... | **Total Costs:** | $0.00 |
| **PAYMENT TYPE** | ☐ **Cheque** Please make payable to the<br>☐ **"Australian Society of Medical Imaging and Radiation Therapy"** | ☐ **Credit Card** Please select the card below<br>☐ **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

To submit via email **Click here** or click on File > Send

Alternatively, you can email the form to MRI@asmirt.org

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

**All Correspondence to:**
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Vic 8007
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