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

APPLICATION FOR CARDIAC INTERVENTIONAL IMAGING (ANGIOGRAPHY) 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: CARDIAC INTERVENTIONAL IMAGING (ANGIOGRAPHY) LEVEL 1 CERTIFICATION	
CARDIAC LEVEL 1 EXAMINATION TAKEN IN:	Month... 2025

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN ANGIO (CARDIAC)

I, _____ , certify that I have performed over 150 cardiac angiography examinations within the 12- month period between _____ 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 150 cardiac angiography 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			
ANGIO CERTIFICATION NO.		DATE OPERATIVE	
SIGNED			
PAYMENT RECEIVED		RECEIPT NO.	

DECLARATION – EDUCATION COMMITTEE

This is to certify that _____

has satisfactorily completed all requirements and is recommended for the award of

CARDIAC INTERVENTIONAL IMAGING (ANGIOGRAPHY) 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 ☐ **"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

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

Registered Office:
Suite 1040 (Level 10)
1 Queens Road
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Australia

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