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 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 B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN CARDIAC LEVEL 1

I, _____, certify that I have performed over 450 clinical cardiac angiographic examinations (minimum 150 clinical cardiac angiographic examinations per year must be completed every 12-months within the 3-year period) 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 450 clinical cardiac angiographic examinations with a minimum of 150 completed every 12 months within this 3-year period).

Signed:_____ Date:_____

Position:_____ Name of Site:_____

SUPERVISOR CONTACT DETAILS					
SUPERVISOR NAME					
SITE ADDRESS					
TOWN/SUBURB		STATE		POSTCODE	
TEL (WORK)		EMAIL			

OFFICE USE ONLY			
ANGIO CARDIAC LEVEL 1 CERTIFICATION		DATE OPERATIVE	
SIGNED			
PAYMENT RECEIVED		RECEIPT NO.	
DATE MAILED			

Registered Office:
Suite 1040-1044 (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

DECLARATION - ASMIRT
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:_____

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/circle the card below **VISA** **MASTERCARD** **AMEX**		
CREDIT CARD				
EXPIRY DATE		**CCV NO.** (LAST 3 DIGITS ON BACK OF CARD, OR LAST 4 DIGITS FOR AMEX)		
CARDHOLDER'S NAME				
CARDHOLDER'S SIGNATURE				

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 1040-1044 (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