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

# APPLICATION FOR RENEWAL
# CERTIFICATE OF MAMMOGRAPHIC PRACTICE

*(Fees current 01 July 2025 Through to 30 June 2026)*

*Please complete with reference to Guidelines for Issue of the*

*Certificate of Mammographic Practice available from 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):

- 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)
- 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)
- 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.

**The following will not be accepted as evidence, so please do not send:**

- Lists of identified patient/client/radiographer information
- Photocopied books or articles, pay slips or times sheets
- Unverified lists of activities.

DO NOT SEND ORIGINALS AS WE CANNOT GUARANTEE THEIR RETURN. **Required documentation attached** ☐ 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 | |

**DECLARATION – OFFICE USE ONLY**

This is to certify that _____ (Applicant's Name) has satisfactorily completed all requirements and is recommended for the award of **CERTIFICATE OF MAMMOGRAPHIC PRACTICE**

Date recommended _____

Signed _____ Date _____

Chairperson – BIRG (print) _____

| 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.***

Clear Payment section

ALTERNATIVE PAYMENT METHOD

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

Quote Ref: Invoice #, or email remittance advice to finance@asmirt.org

Click here

**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

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# CMP CPD ACTIVITY LOG

| | | | |
|---|---|---|---|
| **NAME** | | | |
| **CONTACT NO.** | | **ASMIRT MEMBERSHIP NO.** | |
| **EMAIL ADDRESS** | | | |

Please fill in this CPD log with mammography only activities when submitting your CMP renewal application.

| DATE | BRIEF DESCRIPTION OF MAMMOGRAPHY RELATED ACTIVITY | Min (10 hours/year) |
|---|---|---|
| List date in sequential order per yr ie 3/2/20 | ***For example: reading journals/mammography articles*** | 5 hours |
| 4/3/20 | ***For example: BreastScreen Mammography conference*** | 16 hours |
| 5/5/21 | ***For example: mammography webinar*** | 1 hour |
| | Routine QA, Assessment Clinical visits and MDTM activities MUST be supported by a reflection. | |
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| DATE | BRIEF DESCRIPTION OF ACTIVITY | HOURS/NUMBER |
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**Registered Office:**
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