



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					
<p>I, _____, certify that I have performed over 1000 CT examinations (as described on Page 2) within the <u>3-year period</u> between the dates of _____ and _____.</p> <p>This period must have occurred immediately prior to application submission.</p> <p>Signed _____ Date _____</p>					
SUPERVISOR'S VERIFICATION					
<p>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.</p> <p>Signed _____ Date _____</p> <p>Position _____ Name of Site _____</p>					
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			
			Total Costs:
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:

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Collins Street West
Vic 8007
Australia

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