



APPLICATION FOR ADVANCE PRACTICE CREDENTIALLING

This application form, when completed, is to be forwarded to the Chief Executive of the Society
accompanied by the prescribed fee

APPLICANT'S DECLARATION

I,

(Family Name in Full)

(Given Names in Full)

Of

Street address

Suburb

State

Postal
code

being a Financial Voting Member of the Australian Society of Medical Imaging and Radiation Therapy hereby make
application to submit documentation for advanced practice credentialling:-

Medical Imaging

☐

Radiation Therapy

☐

or Nuclear Medicine

☐

MEMBERSHIP NO.

MEMBERSHIP DIPLOMA NO.

DATE OF ADMISSION AS
A VOTING MEMBER

BRIEF PROFESSIONAL/EMPLOYMENT HISTORY

PRESENT EMPLOYER

BUSINESS ADDRESS

TEL (HOME)

TEL (BUSINESS)

TEL (MOBILE)

EMAIL

Signed

Date

OFFICE USE ONLY

The above details, in regards to membership, have been verified and the appropriate fee received.

Chief Executive

Date

PAYMENT AUTHORITY			
COST			
TOTAL AMOUNT (Including GST) \$			
☐ Cheque – Please make payable to “ Australian Society of Medical Imaging and Radiation Therapy ” (Australian Dollars Only)			
CREDIT CARD (Please tick): ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS			
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

To submit via post,

Please print and send to
PO Box 16234, Collins Street West, VIC 8007

To submit via email,

[Click here](#) or click on File > Send file. The form will then attach in your email client. Forms can be sent to execoff@asmirt.org

To submit via fax,

Please print and fax to 03 9416 0783

Registered Office:

Suite 1040, Level 10
1 Queens Road
Melbourne VIC 3004
Australia

All Correspondence to:

PO Box 16234
Collins Street West
VIC 8007
Australia

Contact Us:

T +61 3 9419 3336
F +61 3 9416 0783
W www.asmirt.org