



APPLICATION FOR **RENEWAL** OF VASCULAR 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 VASCULAR LEVEL 1

I, _____, certify that I have performed over 450 clinical vascular angiographic examinations (minimum 150 clinical vascular 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 vascular 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 **VASCULAR INTERVENTIONAL IMAGING (ANGIOGRAPHY) LEVEL 1 CERTIFICATION.**

Signed: _____ Date: _____

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/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

Updated Jul 2026

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