



APPLICATION FOR RENEWAL CERTIFICATE OF MAMMOGRAPHIC PRACTICE

(Fees current 01 July 2026 Through to 30 June 2027)

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):			
<ul style="list-style-type: none">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:			
<ul style="list-style-type: none">Lists of identified patient/client/radiographer informationPhotocopied books or articles, pay slips or times sheetsUnverified 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			
			Total Costs:
PAYMENT TYPE	Cheque Please make payable to the	Credit Card Please select the card below	
	"Australian Society of Medical Imaging and Radiation Therapy"	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.

Registered Office:

Suite 1040 (Level 10)
1 Queens Road
Melbourne Vic 3004
Australia

All Correspondence to:

P.O. Box 16234
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Vic 8007
Australia

Contact us:

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