



## APPLICATION FOR MAGNETIC RESONANCE IMAGING (MRI) 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 A THEORETICAL COMPONENT: MRI LEVEL 1 CERTIFICATION EXAMINATION			
MRI LEVEL 1 EXAMINATION TAKEN IN:		YEAR	

PART B CLINICAL COMPONENT: STATEMENT OF CLINICAL EXPERIENCE IN MRI	
I, _____, certify that I have performed over 300 clinical MRI examinations within the <u>12-</u> month period between the dates of _____ 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 300 clinical MRI examinations during the time period described above.	
Signed _____	Date _____
Position _____	Name of Site _____

SUPERVISOR CONTACT DETAILS				
SUPERVISOR NAME				
SITE ADDRESS				
TOWN/SUBURB		STATE		POSTCODE
TEL		EMAIL		

OFFICE USE ONLY			
MRI LEVEL 1 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 **MRI LEVEL 1 CERTIFICATION**.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Position \_\_\_\_\_

## PAYMENT AUTHORITY

<b>COSTS</b>			<b>Total Costs:</b>	
<b>PAYMENT TYPE</b>	<b>Cheque</b> Please make payable to the  "Australian Society of Medical Imaging and Radiation Therapy"	<b>Credit Card</b> Please select the card below  <b>VISA</b> <b>MASTERCARD</b> <b>AMEX</b>		
	<b>CREDIT CARD NUMBER</b>			
<b>EXPIRY DATE</b>		<b>CCV NO.</b> (LAST 3 DIGITS ON BACK OF CARD, OR LAST 4 DIGITS FOR AMEX)		
<b>CARDHOLDER'S NAME</b>				
<b>CARDHOLDER'S SIGNATURE</b>				

*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](mailto:finance@asmirt.org)

### 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:

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F +61 3 9416 0783  
W [www.asmirt.org](http://www.asmirt.org)

