



## APPLICATION FOR **RENEWAL** OF CARDIAC 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 CARDIAC LEVEL 1	
I, _____, certify that I have performed over 450 clinical cardiac angiographic examinations (minimum 150 clinical cardiac 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 cardiac 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			

Updated July 2020

### 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](http://www.asmirt.org)

## DECLARATION - ASMIRT

This is to certify that \_\_\_\_\_

Has satisfactorily completed all requirements and is recommended for the award of **CARDIAC INTERVENTIONAL IMAGING (ANGIOGRAPHY) LEVEL 1 CERTIFICATION.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## PAYMENT AUTHORITY

<b>COSTS</b>			<b>Total Costs:</b>	
<b>PAYMENT TYPE</b>	<p><b>Cheque</b> Please make payable to the</p> <p><b>"Australian Society of Medical Imaging and Radiation Therapy"</b></p>	<p><b>Credit Card</b> Please select/circle the card below</p> <p style="text-align: center;"> <b>VISA</b>                      <b>MASTERCARD</b>                      <b>AMEX</b> </p>		
<b>CREDIT CARD</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>				

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