Australian Society of Medical Imaging and Radiation Therapy
The national professional organisation representing medical radiation practitioners
ABN 26 924 779 836

APPLICATION FOR CERTIFICATE OF PROVISIONAL RECOGNITION

Complete this form if you are:

- An Australian graduate who has completed an MRPBA approved program and requires provisional recognition and
- not an ASMIRT member

Do not complete this form if you:

- Are an overseas qualified practitioner or
- You are an ASMIRT member (ASMIRT members receive this certificate as part of their provisional membership.

CONTACT DETAILS

SURNAME										
MAIDEN NAME (If Applicable)										
GIVEN NAMES										
TITLE: MR/MRS/MS/MISS/OTHER			DATE OF BIRTH							
POSTAL ADDRESS										
TOWN/SUBURB		STATE				POSTCODE				
COUNTRY (Applicable for Overseas Applicants only)										
TEL (H)			TEL (M)							
EMAIL										

PERSONAL DETAILS AND QUALFICATIONS

AHPRA REGISTRATION			
UNIVERSITY ATTENDED			
YEAR COMMENCED		YEAR COMPLETED	
QUALFIICATION OBTAINED			
DISCIPLINE	☐ DIAGNOSTIC RADIOGRAPHY	☐ RADIATION THERAPY	

DOCUMENT REQUIREMENTS	
ENGLISH LANGUAGE REQUIREMENT	All English Language requirements must be certified All applicants are required to show proof of their English language requirement or proof of their provisional registration with AHPRA
	☐ I hold provisional registration with AHPRA ☐ I am submitting my English language requirement with this application
	Please note: If you do not hold provisional registration with AHPRA you will be required to submit a certified copy of one (1) of the English language requirements listed on AHPRA's website under the English language standard
QUALIFICATION REQUIREMENT	All Qualification requirements must be certified You are required to show proof that you have completed an Australian MRPBA approved program of study. In some cases your university will supply a list of successful graduates to ASMIRT. In the event they do not supply this list you will be required to submit confirmation of your successful completion
	☐ I have provided consent to my university and they are supplying a list to ASMIRT ☐ I have attached a certified copy of my degree certificate of certified confirmation of my completion

FORM AUTHORITY			
DATE SUBMITTED		DATE OF BIRTH	
SIGNATURE			
By signing this form you agree the information provided is true and accurate.			

OFFICE USE ONLY					
DATED				CERTIFICATE NO.	
TOTAL AMOUNT RECEIVED	**$183**	☐ Yes	☐ No	RECEIPT NO.	
INFORMATION MAILED TO:	☐	APPLICANT	☐	OTHER	

PAYMENT AUTHORITY			
APPLICATION FOR ISSUE OF ASMIRT CERTFICATE OF PROVISIONAL RECOGNITION			
FEES	Certificate of Provisional Recognition $183 (inc GST)		
PAYMENT TYPE	☐ CREDIT CARD	☐ CHEQUE (Please send cheque to the **Australian Society of Medical Imaging and Radiation Therapy**, PO Box 16234 Collins Street West VIC 8007	
CREDIT CARD TYPE	Please select...	**CREDIT CARD NUMBER**	
EXPIRY DATE		**CCV NUMBER**	
		(Last 3 digits on back of card, or last 4 digits for AMEX)	
SIGNATURE			

Cash is not accepted

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 certification@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:
P.O. Box 16234
Collins Street West
Vic 8007
Australia

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