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

APPLICATION FOR
TIME EXTENSION FOR RENEWAL OF CT INTERMEDIATE LEVEL 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			

APPLICANT'S DECLARATION

I, _____, wish to apply for an extension of my

☐ **Renewal CT INTERMEDIATE LEVEL Certification** for a period of _____ months

The reason for this request is:

Signed _____ Date _____

The application must be completed in full and signed by the applicant before it can be processed.
Supporting documentation MUST be attached to the application for review by ASMIRT. (Doctor's Certificates, Letter from Employer, Statutory Declaration etc). Extension period granted is at the discretion of ASMIRT.

OFFICE USE ONLY

CT CERTIFICATION NO.		NEW EXPIRY	
SIGNED			
DOCUMENTATION ATTACHED	☐ YES		☐ NO

DECLARATION – ASMIRT

This is to certify that _____

has been approved for a time extension for the renewal of their certification. The granted extension is for _____ months.

Signed _____ Date _____

Name _____ Position _____

Registered Office:
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