



APPLICATION FOR CERTIFICATE OF RECOGNITION IN ULTRASOUND BY GRADUATES OF ASAR-ACCREDITED ULTRASOUND PROGRAMS

(01 July 2022 Through to 30 June 2023)

CONTACT DETAILS (Please PRINT clearly in blue or black pen)										
SURNAME										
CERTIFICATE NAME (include evidence of change of name if applicable)										
GIVEN NAMES										
TITLE: MR/MRS/MS/MISS/ OTHER										
DATE OF BIRTH		D	D	M	M	Y	Y	Y	Y	
RESIDENTIAL ADDRESS										
TOWN/SUBURB					STATE				POSTCODE	
COUNTRY										
TEL (BH)					TEL (AH)					
MOBILE										
EMAIL										

NAME OF QUALIFICATION GAINED OUTSIDE AUSTRALIA										
NAME OF UNIVERSITY ATTENDED										
CITY					COUNTRY					
TITLE OF QUALIFICATION OBTAINED										
DATE COURSE COMMENCED		D	D	M	M	Y	Y	Y	Y	
DATE COURSE COMPLETED		D	D	M	M	Y	Y	Y	Y	

NAME OF QUALIFICATION GAINED WITHIN AUSTRALIA										
NAME OF UNIVERSITY ATTENDED										
CITY										
TITLE OF QUALIFICATION OBTAINED										
DATE COURSE COMMENCED		D	D	M	M	Y	Y	Y	Y	
DATE COURSE COMPLETED		D	D	M	M	Y	Y	Y	Y	
PLACE OF EMPLOYMENT										
EMPLOYER ADDRESS										
START DATE OF EMPLOYMENT		D	D	M	M	Y	Y	Y	Y	

POST-QUALIFICATION CLINICAL EXPERIENCE

My post-qualification clinical experience was gained: please tick one box only

- Exclusively in Australia
- Exclusively outside Australia
- Both in Australia and overseas

Please supply with this application form a letter on University letterhead, signed and dated by the course coordinator outlining the department in which you have undertaken your clinical experience. (Department name, address and contact number).

FORM OF AGREEMENT

I declare that the information I have supplied in this application is complete, up-to-date and correct in every detail and that I understand that if I give false or misleading information, my application may be refused.

APPLICANT SIGNATURE		DATE	
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GUIDE TO COMPLETING THIS APPLICATION FORM AND SUPPORTING DOCUMENTATION

In order for the ASMIRT to process a Certificate of Recognition in Ultrasound, applicants from ASAR-accredited ultrasound programs are to complete and sign this application form and return it by post to:

**Australian Society of Medical Imaging and Radiation Therapy
PO Box 16234
COLLINS STREET WEST. VIC. 8007
Australia.**

Do not fax or email these documents, as they will not be accepted.

The following supporting documentation is to accompany the application:

1. A certified copy* of your previous qualification/s obtained outside Australia
2. A certified copy* of your Australian gained ultrasound qualification
3. A certified copy* of your ASAR Registration
4. A certified copy* of your marriage certificate or change name, if applicable
5. Employer verification of current employment status
6. Payment of \$309.00 Australian Dollars (payment made by Bank Draft drawn on an Australian bank or Credit Card: VISA, MasterCard, American Express).
7. Overseas currency is not accepted. **Do not send cash.**
8. Evidence of understanding and fluency in English (i.e. IELTS/OET and certified copy* of Passport or Birth Certificate if you are not a citizen of Australia, New Zealand, Canada, Republic of Ireland, United Kingdom or United States of America)
9. Evidence of the past three years of Continuing Professional Development

The ASMIRT requirement of English Proficiency is evidence of one of the following:

- Birth Certificate – *Australia issued*
- Passport – *Australia, New Zealand, Canada, Republic of Ireland, United Kingdom or United States of America issued*
- IELTS – *overall band score of not less than 7 Academic with no element below 7 achieved in a single test*
- OET – *overall minimum of Level B in all elements achieved in a single test*

Do not send original documents. **Certified copies*** are to be submitted. Processing of applications takes up to three weeks.

* A "certified Copy" of a document means a copy authorised or stamped as being a true and unaltered copy of the original document by a person or agency recognised by the law of your country. In Australia, it must be certified by a Justice of the Peace, Commissioner for Declarations of a person before whom a statutory declaration may be made. e.g. accountant, lawyer, doctor, police office.

CHECKLIST

These documents are to be included or your application will not be processed:

DOCUMENT	INCLUDED
1. Completed and signed application form (original)	YES/NO
2. Payment of \$309.00 Australian Dollars	CHEQUE/CREDIT CARD
3. Passport size photo	<div style="border: 1px solid black; padding: 20px; width: fit-content; margin: auto;"> <p style="text-align: center;">Attach certified passport size photo here</p> </div>
4. CERTIFIED COPIES OF:	
a) Qualification/s gained outside Australia	YES/NO
b) Sonography Qualification gained within Australia	YES/NO
c) Registration Certificate/Licence	YES/NO
d) Verification of Employment – with % breakdown	YES/NO
e) Letter from university outlining clinical experience	YES/NO
f) Marriage certificate or change of name, if applicable	YES/NO
g) Evidence of English fluency and understanding	YES/NO
h) Evidence of the past three years of Continuing Professional Development (CPD)	YES/NO

OFFICE USE ONLY

OQAP APPROVED		CERTIFICATE NO	
ASAR COURSE YEAR		DATE OPERATIVE	
COUNTY		SIGNED	
		POSTED	
ULTRASOUND		PAYMENT TAKEN: <input type="checkbox"/> AUD \$309.00	
		ADMIN. OFFICER	

PAYMENT AUTHORITY

APPLICATION FOR ISSUE OF ASMIRT CERTIFICATE OF RECOGNITION IN ULTRASOUND & SKILLS ASSESSMENT (Required for ASAR Registration)

COST \$AUD 309.00 (inc GST)

Payment of FEE, which must be included with the Application Form, is to be in Australian Dollars drawn on an Australian Bank or by MasterCard/Visa Card/American Express. Overseas currency is not acceptable. Do not send cash.

Cheque – Please make payable to “**Australian Society of Medical Imaging and Radiation Therapy**” (Australian Dollars Only)

CREDIT CARD (Please tick): **MASTERCARD** **VISA** **AMERICAN EXPRESS**

EXPIRY DATE _____

CCV NO. _____
(LAST 3 DIGITS ON BACK OF CARD, OR 4 DIGITS ON FRONT OF CARD)

SURNAME OF CARDHOLDER (Please Print)

I hereby authorise the Australian Society of Medical Imaging and Radiation Therapy to debit the said amount as payment for Certificate of Recognition in Ultrasound Fee:

SIGNATURE OF CARDHOLDER

APPLICANT'S NAME

ADDRESS

DATE

Submit via post,
Please print and send to
PO Box 16234, Collins Street West, VIC 8007

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

