



ABN 26 924 779 836

Australian Institute of Radiography

APPLICATION FOR RESUMPTION OF PROFESSIONAL PRACTICE PROGRAMME

NOTICE TO APPLICANTS

Applicants should read the AIR Resumption of Professional Practice guidelines prior to submitting this application. These guidelines describe the application assessment process.

All sections of this application should be completed and supporting documentation attached. If more space is required for any section, please attach additional pages. Your application **will not** be considered until all the requested information and documentation is received.

Section A

Attach evidence of change of name, if applicable

Section B

Attach copy of your primary radiography or radiation therapy qualification

Attach copies of certificates or transcripts for other professionally relevant study

Section C

Attach curriculum vitae

Other documents

Attach completed application for Provisional Statement of Accreditation, available at www.air.asn.au

Attach completed application for Provisional Membership of the AIR, available at www.air.asn.au, or confirmation of arrangements for professional indemnity insurance cover

APPLICANT'S DECLARATION

I declare that the information I have supplied in this application is complete and correct and up to date in every detail.

I understand that if I give false or misleading information, my application may be refused or my Resumption of Professional Practice programme may be cancelled.

Applicant's signature _____

Date

Post your application to:

AUSTRALIAN INSTITUTE OF RADIOGRAPHY

P O Box 16234

Collins Street West, Victoria 8007

Telephone +61 3 9419 3336

Fax +61 3 9416 0783

Email paeb@air.asn.au

Web site www.air.asn.au

SECTION A

PERSONAL DETAILS

Attach evidence of change of name if applicable

Title Mr Mrs Miss Ms Dr

Surname/Family name

Given names

Other previous names

Street Address

Town/Suburb

State

Postcode

Telephone (mobile)

Telephone (home)

Telephone (work)

Email address

Date of Birth / /

SECTION B

RADIOGRAPHY OR RADIATION THERAPY PRIMARY QUALIFICATION

Attach copy of qualification document

Title of qualification obtained

Name of university / institution attended

Level of qualification Certificate Associate Diploma Diploma Degree Master

Year of qualification

Have you ever been issued with: Conjoint Board Diploma AIR Statement of Accreditation

Date of issue / / *Document number*

SECTION D SUMMARY OF RADIOGRAPHY OR RADIATION THERAPY PROFESSIONAL KNOWLEDGE & EXPERIENCE

	Included in academic studies?	Description of postgraduate clinical experience in this category. Include estimation of duration of experience and an outline of the range of experience.
Radiography		
General x-ray		
Trauma / emergency		
Mobiles		
Operating theatre		
CT		
MRI		
Ultrasound		
Mammography		
Computed Radiography		
Digital Radiography		
Cross-sectional anatomy		
Research		
Radiation therapy		
Megavoltage treatment		
Superficial treatment		
Brachytherapy		
Conventional simulation		
CT simulation		
3D treatment planning		
Cross-sectional anatomy		
Research		