

**Application for Validated Statement of Accreditation**

Surname \_\_\_\_\_ Membership No. \_\_\_\_\_

Maiden Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Change of name requires certified marriage certificate)

Given Names \_\_\_\_\_

Title (circle one) Mr Mrs Ms Miss Other \_\_\_\_\_

Address \_\_\_\_\_

Town/Suburb \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Tel (H) \_\_\_\_\_ Tel (M) \_\_\_\_\_

Email \_\_\_\_\_

University attended \_\_\_\_\_ Year \_\_\_\_\_

Qualification obtained \_\_\_\_\_

Discipline (circle one) Diagnostic Therapy Mammography only

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

I understand the Validated Statement of Accreditation I am applying for is valid for a 3-year period after which time a further validated Statement of Accreditation will be issued on evidence of Continuing Professional Development (CPD).

Signature of applicant \_\_\_\_\_

Date \_\_\_\_\_

**I am an International Student and will require a Skills Assessment letter included for Immigration purposes.**

**Applications will not be processed until the AIR receives notification that graduates have successfully completed an NPDP year or course of academic study.**

**OFFICE USE ONLY**

Accreditation No. \_\_\_\_\_ Date Operative \_\_\_\_\_

Signed \_\_\_\_\_ Expiry Date \_\_\_\_\_

Certificate sent to (circle) Applicant Other \_\_\_\_\_

Date Mailed \_\_\_\_\_

**PLEASE NOTE** All graduates are required to provide evidence of English Proficiency with this form. Documents must be a certified copy.

Examples are Birth Certificate – *Australia issued*  
Passport – *Australia, New Zealand, Canada, Singapore, 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*

**Tick if previously supplied.**

Application for the issue of Validated Statement of Accreditation

**Cost** \$220.00 AUD (incl. \$22.00 GST)

Enclosed is a cheque for \$220.00 AUD  
\*made payable to Australian Institute of Radiography

Charge cost to (circle one) Visa MasterCard American Express

Name of cardholder (print) \_\_\_\_\_

Card No. \_\_\_\_\_

Expiry Date \_\_\_\_\_ CCV No. \_\_\_\_\_ (last 3 digits on back of card)

Signature of cardholder \_\_\_\_\_



AUSTRALIAN INSTITUTE  
OF RADIOGRAPHY

ABN 26 924 779 836

Application for

**VALIDATED STATEMENT OF ACCREDITATION**

PO Box 16234 Collins Street West  
Victoria 8007

Tel (03) 9419 3336 Fax (03) 9416 0783

Email [air@air.asn.au](mailto:air@air.asn.au)

Website [www.air.asn.au](http://www.air.asn.au)

AIR Registered Office  
25 King Street Melbourne Victoria 3000 Australia