



REGISTERED OFFICE

25 KING STREET, MELBOURNE
VICTORIA 3000

AUSTRALIAN INSTITUTE OF RADIOGRAPHY

ABN 26 924 779 836

APPLICATION FOR:

VALIDATED STATEMENT OF ACCREDITATION

**FOR GRADUATES OF
OVERSEAS PROGRAMS IN RADIOGRAPHY AND
RADIATION THERAPY ACCREDITED BY THE
AUSTRALIAN INSTITUTE OF RADIOGRAPHY**

P.O. BOX 16234, COLLINS STREET WEST, VICTORIA, AUSTRALIA, 8007
TELEPHONE: 61 3 9419 3336. FAX: 61 3 9416 0783
Email Enquiries : osassess@air.asn.au

October 2010

AUSTRALIAN INSTITUTE OF RADIOGRAPHY

**APPLICATION FOR VALIDATED STATEMENT OF ACCREDITATION
BY GRADUATES OF AIR-ACCREDITED OVERSEAS COURSES**

Contact details: (Please PRINT clearly in blue or black pen)

TITLE: Mr Mrs Miss Ms Other _____ SURNAME: _____

GIVEN NAMES: _____

CERTIFICATE NAME: _____
(include evidence of change of name if applicable)

POSTAL ADDRESS: _____

_____ COUNTRY: _____

DATE OF BIRTH: ___/___/___ EMAIL ADDRESS: _____

TELEPHONE: BH: _____ AH: _____

Qualifications:

NAME OF UNIVERSITY ATTENDED: _____

CITY _____ COUNTRY _____

TITLE OF QUALIFICATION OBTAINED: _____

DIAGNOSTIC OR RADIATION THERAPY

DATE COURSE COMMENCED: ___/___/___ DATE COURSE COMPLETED: ___/___/___

PLACE OF EMPLOYMENT _____

ADDRESS _____ START DATE OF EMPLOYMENT: _____

I declare that the information I have supplied in this application is complete, up-to-date and correct in every detail and 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 three 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: _____

GUIDE TO COMPLETING THIS APPLICATION FORM AND SUPPORTING DOCUMENTATION

DO NOT COMPLETE THIS FORM IF YOUR QUALIFICATION IS NOT LISTED ON THE ACCREDITED DEGREE PROGRAMS LIST. For more information see:

www.air.asn.au then Overseas Qualifications then Pre-Approved courses.

If your qualification is listed as a degree program accredited by the AIR, the instructions are as follows:

In order for the AIR to process a Validated Statement of Accreditation, applicants from overseas degree programs accredited by the AIR are to complete and sign this application form and return it by post to:

**Australian Institute of Radiography
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 Radiography or Radiation Therapy qualifications from the AIR-accredited University program
2. a certified copy of your current Registration/Practising Certificate/Licence from the country of your qualification
3. a certified copy of your marriage certificate or change of name, if applicable
4. Employer verification of clinical experience post graduation (12months' minimum)#
5. Payment of \$220.00 Australian Dollars (payment made by Bank Draft drawn on an Australian bank or Credit Card: VISA, MasterCard, American Express.)
6. Overseas currency is not accepted. Do not send cash.
7. Evidence of understanding and fluency in English (see website)

Do not send original documents, as their return cannot be guaranteed. Certified copies are to be submitted. Processing of applications takes up to two 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 or a person before whom a statutory declaration may be made. e.g. accountant, lawyer, doctor, police officer.

Employer verification of clinical experience post graduation:

Substantiated evidence is required from your employer verifying your Radiography/Radiation Therapy experience. The minimum requirement is 12 months' experience.

This evidence of clinical experience should be from a Superintendent Radiographer/ Radiation Therapist, Head of Department or similar and written on hospital or centre letterhead.

The letter/s must state:

- The start and end dates of your employment as a radiographer at the hospital/centre and whether your employment was full or part time.
- The work performed by you, including duties and responsibilities, participation in shift work or “on-call” work if relevant. A percentage breakdown of different modalities must be included e.g.50% general radiography, 30% CT Scanning, 20% mammography etc. or 80% Treatment and 20% Simulation & Planning.

A personal employment history or resume may be submitted but is not acceptable as a substitute for the above.

CHECK LIST

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 \$220.00 Australian Dollars	CHEQUE / CREDIT CARD
3) CERTIFIED COPIES OF:	
a) Radiography or Radiation Therapy qualifications from the AIR-accredited University Program	YES / NO
b) Current Registration/Practising Certificate/Licence	YES / NO
c) Employer verification of clinical experience post graduation. (12months' minimum) #	YES / NO
d) Marriage certificate or change of name, if applicable	YES / NO
e) Evidence of English fluency and understanding	YES / NO / NA

OFFICE USE ONLY

OQAP Approved: _____

Accreditation No: _____

PAEB Accredited Course: _____

Date Operative: _____

Country: _____

Signed: _____

Diag Radiation Therapy

Posted: _____

Previous Reciprocal Agreement: _____

Faxed to: _____

Other: _____

Payment taken: AUD\$220.00 No Fee

Admin. Officer: _____

Duplicate issued: _____

PAYMENT AUTHORITY
Application for Issue of AIR
Validated Statement of Accreditation
(Required for Registration/Licensing)

COST: \$AUD220.00

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 made payable to: "Australian Institute of Radiography"

Credit Card details: *Select one:*

Visa

MasterCard

American Express

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Expiry Date / /

Surname of Cardholder (Please Print) _____

I hereby authorise the Australian Institute of Radiography to debit the said amount as payment for Statement of Accreditation Fee:

Signature of Cardholder: _____

APPLICANT'S NAME: _____

ADDRESS: _____

DATE: _____

NOTE: Rebate of AUD\$100.00 given off Membership Subscription if membership application received at the AIR Office within three (3) months of receipt of this form and remittance.