APPLICATION FOR CERTIFICATE OF ACCREDITATION IN MAGNETIC RESONANCE IMAGING LEVEL 1

OFFICE USE ONLY

CA MRI Level 1 No. ____________

Date processed ____________

Receipt No. ____________

AIR staff member ____________

AUSTRALIAN INSTITUTE OF RADIOGRAPHY

ABN 26 924 779 836

Application for

CERTIFICATE OF ACCREDITATION in MAGNETIC RESONANCE IMAGING LEVEL 1

PO BOX 1169 COLLINGWOOD
VICTORIA 3066
AUSTRALIA

Tel (03) 9419 3336 Fax (03) 9416 0783
Email air@air.asn.au
Website www.air.asn.au

AIR Registered Office
32 Bedford Street Collingwood Victoria 3066 Australia

Rev. July 2009

AUSTRALIAN INSTITUTE OF RADIOGRAPHY

Application for

MAGNETIC RESONANCE IMAGING LEVEL 1 ACCREDITATION

Surname ______________________ Date of birth __ __ / __ __ / __ __

Maiden name ______________________

Given names ______________________

Title (circle one) Mr Mrs Ms Other

Address ______________________

____

Town/Suburb ____________ State ________ Postcode ________

Tel (W) ____________ Tel (H/M) ____________

Email ______________________

Validated Statement of Accreditation No. ____________

Accredited MRI Exam undertaken at ______________ Year ______

Statement of Clinical Experience in Magnetic Resonance Imaging for Level 1 Accreditation

I ______________________

certify that I have performed over 300 MRI examinations during the 12-month period between ______________ and ______________

(This period must be during the past 2 years)

Signed ______________________ Date __ __ / __ __ / __ __

Supervisor's Verification

I ______________________

supervisor of the individual identified on the application verify that the individual has successfully completed 300 MRI examinations during the time period described above.

Signed ______________________ Date __ __ / __ __ / __ __

Position ______________________

Name of Institution ______________________

This application must be completed in full and signed by the applicant and his/her supervisor before it can be processed

OFFICE USE ONLY

Certificate No. ____________ Date operative __ __ / __ __ / __ __

Signed ______________________

Payment received ____________ Receipt No. ____________

Certificate to ☐ Applicant ☐ Other

Mailed ____________

Not Granted – Ref. No. ____________

Signed ______________________

OFFICE USE ONLY

DECLARATION – MIAP 1

This is to certify that ______________________

Applicant's name

has satisfactorily completed all requirements and is recommended for the award of:

CERTIFICATE OF ACCREDITATION IN MRI LEVEL 1

Signed ______________________ Date __ __ / __ __ / __ __

Name ______________________

Position ______________________

(Print)

AUSTRALIAN INSTITUTE OF RADIOGRAPHY
ABN 26 924 779 836

MAGNETIC RESONANCE IMAGING LEVEL 1

REMITTANCE ADVICE
This section must be mailed by the applicant with required remittance to

Executive Officer
Australian Institute of Radiography
PO BOX 1169 Collingwood Victoria 3066 Australia

Surname ______________________

Given names ______________________

Title (circle one) Mr Mrs Ms Other

Address ______________________

____

Town/Suburb ____________ State ________ Postcode ________

Tel (W) ____________ Tel (H/M) ____________

Email ______________________

Application for the Certificate of Accreditation in

MAGNETIC RESONANCE IMAGING LEVEL 1

COST

MEMBER	No charge
NON-MEMBER	$A165.00 ($A150.00 + $A15.00 GST)

☐ Enclosed cheque

OR charge cost to ☐ Visa ☐ MasterCard ☐ Amex

Name of cardholder (print) ______________________

Card No. __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiry date __ __ / __ __

Signature of cardholder ______________________