

**APPLICATION FOR CERTIFICATE OF ACCREDITATION
IN MAGNETIC RESONANCE IMAGING LEVEL 1**

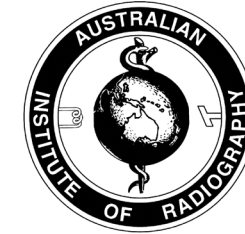
OFFICE USE ONLY

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

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 individ-
ual 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 _____