



REGISTERED OFFICE

32 BEDFORD STREET, COLLINGWOOD  
VICTORIA 3066

# **AUSTRALIAN INSTITUTE OF RADIOGRAPHY**

ABN 26 924 779 836

APPLICATION FOR:

## **STATEMENT OF ACCREDITATION**

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

P.O. BOX 1169, COLLINGWOOD, VICTORIA, AUSTRALIA, 3066  
TELEPHONE: 61 3 9419 3336. FAX: 61 3 9416 0783  
Email Enquiries : [osassess@A-I-R.com.au](mailto:osassess@A-I-R.com.au)

22<sup>nd</sup> April 2004

**AUSTRALIAN INSTITUTE OF RADIOGRAPHY**

**APPLICATION FOR 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.*

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:**

Overseas / [Assessment of Overseas Qualifications](#) &  
Overseas / [Accredited Degree Programs](#)

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 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 1169  
COLLINGWOOD. VIC. 3066  
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.)  
Overseas currency is not accepted. Do not send cash.

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 are to 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 is a helpful way of itemising this 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
<b>3) CERTIFIED COPIES OF:</b>	
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

### 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**  
**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.

E M BADAWEY  
Executive Officer  
22<sup>nd</sup> April 2004