**Enrol for Remote Area Radiology**

The ACRRM Remote Area Radiology Program is only available to ACRRM members or to non members providing short term locum services at the private practice of a current ACRRM member.

[ ]  ACRRM Member – Please fill in Section 1

[ ]  Non ACRRM Member – Please fill in both Section 1 and 2

**Important Notice –** Please provide details of short term locums to ACRRM 5 days prior to date of commencement to allow Medicare rebates to begin on date of commencement.

**SECTION 1:**

**ACRRM Member Details:**

|  |  |
| --- | --- |
| Member Name:      | ACRRM Number:      |
| Email:        | Contact Number:       | DOB:       |

**Medical Practice Details:**

|  |
| --- |
| Medical Practice Name:       |
| Street or Postal Address:       |
| Town:       | State:       | Postcode:       |
| Telephone:       | Facsimile:       |
| Email:       | Provider Number:       |

**Member’s Declaration:**

I,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wish to enrol in the ACRRM Remote Area Radiology Program and agree to comply with all requirements of the program (refer to the ACRRM website) for the current triennium.

|  |  |
| --- | --- |
| Signature: | Date:       |

**SECTION 2:**

**Non ACRRM Member Details – providing short term locum services only (if applicable)**

|  |  |
| --- | --- |
| Name:       | Provider Number:       |
| Email:       | Contact Number:       | DOB:       |
| Commencement Date:       | Signature:       |