**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: | | |