

SOCIETY AND COLLEGE OF RADIOGRAPHERS (SCoR)

APPLICATION FORM FOR INCLUSION ON THE REGISTER OF

SURNAME: **TITLE:**

FORENAMES:

CONTACT ADDRESS:

(will be used by SCoR
when nominating assessors)

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WORK TELEPHONE NO: **EMAIL:**

HPC REGISTRATION NO:..... **SoR MEMBERSHIP NO:**

QUALIFICATIONS:

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PRESENT POST (including grade):

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DETAILS OF INVOLVEMENT IN PROFESSIONAL ACTIVITIES AT A REGIONAL OR NATIONAL LEVEL:

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DETAILS OF CURRENT INVOLVEMENT IN EDUCATION PROGRAMMES:

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DETAILS OF EXPERIENCE OF MULTI DISCIPLINARY EDUCATION

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ANY OTHER INFORMATION RELEVANT TO THIS APPLICATION

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I wish to be considered for the following activities (Please tick all boxes that apply):

Modality or Discipline

- | | | | |
|------------------------|--------------------------|-----------------------|--------------------------|
| Diagnostic Radiography | <input type="checkbox"/> | Radiotherapy/Oncology | <input type="checkbox"/> |
| Ultrasound | <input type="checkbox"/> | Nuclear Medicine | <input type="checkbox"/> |
| Magnetic Resonance | <input type="checkbox"/> | | |

Approval of Programmes

- | | | | | | |
|---------------|--------------------------|--------------|--------------------------|------------------------|--------------------------|
| Undergraduate | <input type="checkbox"/> | Postgraduate | <input type="checkbox"/> | Assistant Practitioner | <input type="checkbox"/> |
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Accreditation of Individuals

Assistant Practitioner	<input type="checkbox"/>	Advanced/Specialist	<input type="checkbox"/>	Consultant	<input type="checkbox"/>
Senior management posts	<input type="checkbox"/>	Senior academic appointments			<input type="checkbox"/>

Specific Area(s) of Practice

Reporting	<input type="checkbox"/>	Treatment prescribing/review	<input type="checkbox"/>
CT	<input type="checkbox"/>	Counselling/ Patient advocacy	<input type="checkbox"/>
GI studies	<input type="checkbox"/>	Multi- professional education	<input type="checkbox"/>
Mammography	<input type="checkbox"/>	Dental Radiography	<input type="checkbox"/>
Radiation Protection	<input type="checkbox"/>	Osteoporosis / DEXA	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	IV administration	<input type="checkbox"/>
Trauma imaging	<input type="checkbox"/>	Forensic radiography	<input type="checkbox"/>

Other activity

Expert witness	<input type="checkbox"/>	Research	<input type="checkbox"/>
Quality Assurance	<input type="checkbox"/>	Clinical effectiveness	<input type="checkbox"/>

Please state any other area of interest:

I agree to accept and work within the guidelines established by the Society and College of Radiographers

SIGNATURE: **DATE:**

***Please return this form to the Accreditation Department,
Society and College of Radiographers, 207 Providence Square, Mill Street,
London, SE1 2EW***