



## NOTICE OF INTENTION TO PRACTICE

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Other names: \_\_\_\_\_ ID: \_\_\_\_\_

Date and location of Theoretical Course attended \_\_\_\_\_

Date of successful logbook submission \_\_\_\_\_

I intend to practice as an accredited practitioner / operator performing Nuchal Translucency ultrasound examinations using the FMF First Trimester Screening Program software.

I understand that by being added to a centre license that I become part of a quality assurance program, and that I am required to submit data and images to the Nuchal Translucency Program during audit periods and at other times as requested by the program assessors.

- I intend to practice as an accredited operator setting up a **new practice / centre**.  
(Please complete Section A )
- I intend to practice as an accredited operator as part of an **established group practice / centre currently using the FMF Software**.  
(Please complete Section B )

*The FMF Software will only be distributed to accredited operators intending to set up a new practice.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Section A.

Name of Centre \_\_\_\_\_

Site Address:  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Section B.**

Please list all centres who would like you to be added to their FMF Software centre license:

State	Suburb / Town (Practice location)	Centre ID	Contact persons signature

Please submit this form to:

Mrs Lai Yue Aitken  
Nuchal Translucency- Ultrasound, Education and Monitoring Program  
RANZCOG  
254 - 260 Albert Street  
East Melbourne VIC 3002

Contacts:  
Phone: 03 8415 0827  
Fax: 03 9417 7795  
[nuchaltrans@ranzcof.edu.au](mailto:nuchaltrans@ranzcof.edu.au)

You can find details regarding the program on our website:  
Regulations, Protocols for measuring the NT, and more:  
[www.nuchaltrans.edu.au](http://www.nuchaltrans.edu.au)