APPLICATION FOR AUTHORIZED MEDICAL PHYSICIST

Date of Application: ____________

[ ] New application/reapplication (complete all sections, including Attachment A)

[ ] Amendment to authorization # ____
(complete section I, V & other applicable sections)

I. APPLICANT INFORMATION

Name: ____ SSN:______-_____-_______

UC Title: [ ]No UC Title; have title of medical physicist at one of the employment institutions below

[ ]Assist. Professor [ ]Assoc. Professor [ ]Professor [ ]Other ______________________

Employer's Title:____

Employment Institution [ ]UC [ ]CCHMC [ ]SHC Dept: ________________________

Office Location:____________ ML:______ Phone:_____________ E-mail:___________________

II. TRAINING AND EXPERIENCE

The minimum training and experience requirements for an authorized medical physicist are designated by regulation. Each new applicant must submit a completed Attachment A, along with copies of any board certification(s), advanced degree(s) and previous employer authorized medical physicist approval(s) applicable for the procedures requested. Any concerns and/or questions regarding the minimum training and experience requirements should be addressed with the Radiation Safety Officer (558-4110).

Indicate below attachments to the application.

[ ] Completed attachment A

[ ] Board certification(s) from ____

[ ] Master's degree/Doctorate degree from ____

[ ] Prior authorized medical physicist approval from __________________________________

III. REQUESTED PROCEDURE(S)

√	PROCEDURES
	Therapeutic radiological physics – standard low dose rate brachytherapy
	Therapeutic radiological physics - ophthalmic treatment
	Therapeutic radiological physics - high dose rate remote afterloader (HDR)

IV. APPLICATIONS CAUTIONS

The Radiation Safety Committee (RSC) shall not approve this application if there is insufficient documentation that regulatory required training and experience has been obtained. RSC approval of this application does not indicate approval as a RAM radiation worker. Handling of RAM is performed as a RAM radiation worker under the supervision of an Authorized User.

In addition to any previous training, all Authorized Medical Physicists (AMP) must complete the training specified in the Medical Physicist Procedures Manual (AMP Manual) prior to being designated as an AMP and for each high dose rate remote afterloader (HDR), manufacturer's training or equivalent must be

completed prior to an individual acting as an AMP for the HDR.

V. ATTESTATIONS

I understand that use of radioactive material under this authorization is limited to standard clinical practice as approved under State of Ohio regulations.

As an Authorized Medical Physicist (AMP), I understand that upon approval of this application, I assume full responsibility for my authorization's safe use and overall compliance to the rules and regulations governing the use of radioactive material and duties assigned to an AMP under the Radiation Control and Safety Program. I understand that this responsibility covers not only myself, but all persons, possibly including my supervisor, who perform medical physicist duties under the authorization.

____ __________

APPLICANT SIGNATURE DATE

As the Department Chairperson, I support the Radiation Safety Committee approving this individual to function as an AMP within the Radiation Control and Safety Program and have verified the applicant's credentials as listed in attachment A. I understand that upon approval of this application I (or my successor) assumes the ultimate fiscal responsibility for payment of charges associated with medical physicist duties described within this application and subsequent amendments (e.g. dosimetry charges). Any costs which are not covered by the AMP (applicant) will be paid from departmental funds.

____ __________

DEPARTMENT/DIVISION CHAIR SIGNATURE DATE

RSC REVIEW AND APPROVAL

[] ***RSC meeting date approval granted*** ____________________________________

[] ***Routed for RSC signature approval***

RSO application review:______________________________ DATE:____________

NOTES:

RSC UC admin. rep. application review:____________________ DATE:____________

NOTES:

<u>Signature documents approval by individual RSC member</u>

RSC CHAIRPERSON:______________________________ DATE:____________

RSC VOTING MEMBER:____________________________ DATE:____________

RSC VOTING MEMBER:____________________________ DATE:____________

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RSC VOTING MEMBER:____________________________ DATE:____________

RSC VOTING MEMBER:____________________________ DATE:____________

RSC VOTING MEMBER:____________________________ DATE:____________

NOTES:

ATTACHMENT A

At minimum must complete either section A or B

SECTION A
SPECIALTY CERTIFICATION

I am board certified as noted below. A copy of the certification is attached. ____________________________________ __________ APPLICANT SIGNATURE Date		
GOVERNING/SPECIALTY BOARD	SPECIALTY/CATEGORY	CERTIFICATION DATE

SECTION B
TRAINING/EXPERIENCE AND PRECEPTOR STATEMENT

I am not board certified. Information regarding applicable training and experience, and appropriate preceptor statements are provided.

____________________________________ __________

APPLICANT SIGNATURE DATE

TRAINING AND EXPERIENCE

FORMAL TRAINING

DEGREE	NAME OF PROGRAM	LOCATION AND CORRESPONDING LICENSE NUMBER	DATES	ORGANIZATION THAT APPROVED PROGRAM (e.g., ACGME)
[ ] Master's [ ] Doctorate	[ ] Physics [ ] Biophysics [ ] Radiological physics [ ] Medical physics [ ] Health physics			
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WORK EXPERIENCE

ONE YEAR FULL-TIME WORK EXPERIENCE

Completed 1-year of full-time training in therapeutic radiological physics under the supervision of ____________________________________ who meets requirements for Authorized Medical Physicist; and

Completed 1-year full-time work experience for ([]HDR []ophthalmic eye applicator) as noted in the next part of this application, under the supervision of ____________________________________ who meets the requirements for Authorized Medical Physicist for the modality(s).

SECTION B
TRAINING/EXPERIENCE AND PRECEPTOR STATEMENT

(continued)

DESCRIPTION OF EXPERIENCE		PROGRAM INFORMATION		TRAINING LENGTH		
procedure		**name of supervising individual**	**location**	**license number**	**clock hours**	**dates**
High Dose Rate Remote Afterloader	**Make _______ Model ______**					
Ophthalmic eye applicator	**Radionuclide(s)_______ __________________**					
Other						

APPLICANT INFORMATION	**TRAINING AND EXPERIENCE INDICATED ON PREVIOUS PAGE WAS OBTAINED UNDER THE SUPERVISION OF:**
FULL NAME	Name of Supervisor
STREET ADDRESS	Name of Institution
CITY STATE ZIP CODE	City State Zip Code

PRECEPTOR STATEMENT

This part must be completed by the individual's preceptor. If more than one preceptor is necessary to document experience obtain a separate preceptor statement from each individual.

[ ] The individual named above has successfully completed 1 year of full-time training in therapeutic medical physics under my supervision.

[ ] The individual named above has successfully completed 1 year of full-time experience under my supervision which included the medical physics aspects associated with ophthalmic treatments sources.

[ ] The individual named above has successfully completed 1 year of full-time experience under my supervision which included the medical physics aspects of high dose rate remote afterloaders.

[ ] I attest the individual designated above completed the training indicated above and upon completion demonstrated the competency to act independently as an Authorized Medical Physicist.

[ ] I certify I am an Authorized Medical Physicist or meet the requirements for an Authorized Medical Physicist.

Preceptor's Signature	Preceptor's Printed/Typed Name	Date

Name of Institution	**MATERIALS LICENSE NUMBER(S)**
City State Zip Code	