PHYSICIST OR SERVICE PROVIDER REGISTRATION
Medical Diagnostic, Radiation Therapy or Other

I would like to be considered as *(check all that apply):*

☐ MEDICAL DIAGNOSTIC X-RAY PHYSICIST

☐ RADIATION THERAPY PHYSICIST

☐ OTHER (please specify): _____

General Information

First Name:	Last Name:	Suffix (Ph.D., MS, BS, Etc.)
Mailing Address:		
City:	State:	Zip:
Primary Phone Number:	Cell Phone Number:	Email Address:
Primary Place of Employment:		
Address: (Street, City, State, ZIP)		
(If Radiation Therapy Physicist) Name of Facility of Employment:		
(If employed at multiple facilities, please complete Appendix A to include each facility)		

Categories of Recognition *(Check applicable Pathway)*

☐ Path One: Nationally Recognized Certifying Body
☐ Path Two: Masters/Ph.D. Degree Plus Training and Experience
☐ Path Three: Alternative Standard

Path One: Nationally Recognized Certifying Body

Board Certification	**Area of Certification**
☐ American Board of Radiology (ABR)	☐ Radiological Physics
☐ American Board of Medical Physics (ABMP)	☐ Diagnostic Radiological Physics
☐ Canadian College of Medical Physics (CCMP)	☐ Therapeutic Radiological Physics
☐ American Board of Health Physics (ABHP)	☐ Roentgen Ray & Gamma Ray Physics
☐ American Academy of Health Physics (AAHP)	☐ X-ray & Radium Physics
☐ Other (please specify)	☐ Other (please specify)

ATTACH COPY OF BOARD CERTIFICATION

Path Two: Degree Plus Training and Experience

☐ Ph.D.	College/University:
☐ M.S.	Date Degree Received:

AND

Minimum of one (1) year full time training and one (1) year full time of professional/clinical work experience under supervision acceptable to the Department.

Training

Date or Date Range:	
Supervised By (Name):	
Supervisor Address (City, State, Zip):	
Supervisor Phone:	
Supervisor Email:	
Facility/Company and Location:	

Professional/Full-Time Work Experience Under Supervision

Date or Date Range:	
Supervised By (Name):	
Supervisor Address (City, State, Zip):	
Supervisor Phone:	
Supervisor Email:	
Facility/Company and Location:	

AND

ATTACH DOCUMENTATION/EVIDENCE OF TRAINING AND PROFESSIONAL/FULL TIME WORK EXPERIENCE

- Copy of Diploma and/or Transcript
- Evidence of Training and Work Experience such as:
  - Detailed description of your experience in Radiation safety including: Facilities, Dates, Supervisors, QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used
  - Supervisor (s) statement describing the nature of the experience and the supervision given. The statement should demonstrate that the supervisor meets the common qualifications of recognition as a Medical Diagnostic X-ray Physicist or Radiation Therapy Physicist.
  - Preceptor Attestation

Preceptor Attestation:

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

I attest that _____ has satisfactorily completed the 1-year of full-time training in medical physics and an additional year of full-time work experience has training and experience that includes hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system; and has achieved a level of competency sufficient to function independently for the types of use for which authorization is sought.

Complete the following for preceptor attestation and signature:

As preceptor, I meet the common qualifications of recognition for the types of use for which the above-named individual seeks authorization.

Name of Preceptor: _____
Signature: _____
Phone Number: _____
Date: _____
Kansas Registration Number: _____

Path Three: Alternative Standard – Recognized by Petition

☐ I do not meet the qualifications specified in Pathway I or II, above. However, I believe that I am qualified to perform or direct competent and dependable radiation safety surveys and/or consultations in the category (or categories) for which I am applying, as I have relevant educational, professional, clinical or technical experience.

Document(s) Submitted to support Petition for Registered Service Provider Status	**Check if enclosed**
Detailed description of your Radiation Safety experience including: Facilities; Dates; Supervisors; QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used	☐
Vendor Specific Training Course(s): Type of Equipment; Manufacturer; Model; Etc.	☐
If documentation is other than above, describe separately at length, in detail: **Note that the burden of evidence is on the petitioner.**	☐

Section III: Areas of Expertise *(Areas of survey specialization for requested recognition of Service Provider Approval)*

My training and experience as described above has enabled me to perform or direct competent and dependable surveys and/or radiation consultation in the following specialized areas; and I am able to provide specific evidence of both training and experience in the areas indicated upon request.

☐ 1. Health Physics Consultation
☐ 2. Diagnostic Radiographic (Medical, Chiropractic, Podiatric)
☐ 3. Mammography (Must conform to Federal MQSA Standards)
☐ 4. Fluoroscopy or Interventional Radiology
☐ 5. Non-Medical, Industrial, Academic, Research
☐ 6. Therapy or Linear Accelerator
☐ 7. Shielding Design
☐ 8. Computed Tomography (C.T.)
☐ 9. Bone Density, DEXA
☐ 10. Dental (Non-CBCT)
☐ 11. Veterinary Radiology
☐ 12. Other (describe below)

_____
_____
_____
_____
_____

Section IV: Availability for Consultation

☐ **I am available for radiation safety consultation or surveys with Kansas registrants for a fee and would like to be included on the Radiation Control Program webpage as a Medical Physicist performing work in Kansas.**

Company Name: _____

Contact Phone: _____ Email Address: _____

Webpage: _____

☐ **I am NOT available for consulting outside my primary workplace.**

Section V: Signature

Signature by the applicant below certifies that:

I certify that the information provided on this application is true and accurate, and I give my permission to the Department officials to verify information as needed.

If my contact information changes, I agree to notify KDHE, Bureau of Community Health Systems, Radiation Control Program, 1000 SW Jackson, Suite 330, Topeka, KS 66612-1365 by phone, email or fax.

Signature of Applicant: _____
Date: _____

Submit this completed form and training certificates to:
Kansas Department of Health and Environment
Bureau of Community Health Systems
Radiation Control Program
1000 SW Jackson, Suite 330
Topeka, KS 66612-1365
Phone: 785-296-1560, Fax: 785-559-4251
Email Address: kdhe.xray@ks.gov

KDHE - RADIATION CONTROL PROGRAM USE ONLY
Approved By:
Date Approved:
Service Provider Number Assigned:

Approved ☐	Not Approved ☐

Comments from Reviewer: