



General Information

| | | |
|---|--------------------|-----------------------------------|
| First Name: | Last Name: | Suffix: (Ph.D., M.S., B.S., etc.) |
| Mailing Address: | | |
| City: | State: | ZIP: |
| Primary Phone Number: | Cell Phone Number: | |
| Email Address: | | |
| Primary Facility of Employment: | | |
| Facility Address: (Street, City, State, ZIP): | | |
| <i>(If employed at multiple facilities, please complete Appendix A to include each facility)</i> | | |

Categories of Recognition *(Check applicable Pathway)*

| |
|---|
| <input type="checkbox"/> Path One: Nationally Recognized Certifying Body |
| <input type="checkbox"/> Path Two: Degree Plus Training and Experience (Masters/Ph.D. Degree) |
| <input type="checkbox"/> Path Three: Alternative Standard |

Path One: Nationally Recognized Certifying Body

| Board Certification | Area of Certification |
|--|--|
| <input type="checkbox"/> American Board of Radiology (ABR) | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> American Osteopathic Board of Radiology (AOBR) | <input type="checkbox"/> Therapeutic Radiology |
| <input type="checkbox"/> Fellow of the Faculty of Radiology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Fellow of the Royal College of Radiology | <input type="checkbox"/> Radiotherapy |
| <input type="checkbox"/> Canadian Royal College of Physicians and Surgeons | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Other (Specify) | |

ATTACH COPY OF BOARD CERTIFICATION

Path Two: Degree Plus Training and Experience

| Description of Training | Location of Training | Clock Hours | Dates of Training |
|---|----------------------|-------------|-------------------|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of ionizing radiation | | | |
| Radiation biology | | | |
| <i>Total Clock Hours (Must be at least 200 hours)</i> | | | |

| Description of Supervised Work Experience | Location of Work Experience | Clock Hours | Dates of Work Experience |
|---|-----------------------------|-------------|--------------------------|
| Review of the full calibration measurements and periodic quality assurance checks | | | |
| Use of administrative controls to prevent misadministration (medical events) | | | |
| Evaluation of prepared treatment plans and calculation of treatment times and patient treatment settings | | | |
| Implementing emergency procedures to be followed in event of the abnormal operation of an external beam radiation therapy unit or console | | | |
| Checking and using survey meters | | | |
| Total Clock Hours (Must be at least 500 hours) | | | |
| Supervising Authorized Username: | | | |

| Description of Supervised Clinical Experience | Location of Clinical Experience | Years of Clinical Experience | Dates of Clinical Experience |
|---|---------------------------------|------------------------------|------------------------------|
| One (1) Year approved residency program | | | |
| Examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment and any limitations/contraindications | | | |
| Selecting proper dose and how it is to be administered | | | |
| Calculating external beam radiation therapy doses and collaborating with the Authorized User in the review of patient progress and consideration of need to modify originally prescribed doses and/or treatment plans as warranted by patients' reaction to radiation | | | |
| Post-administration follow-up and review of case histories | | | |
| Total Years of Clinical Experience (Must be at least one (1) year residency PLUS two (2) years additional experience) | | | |
| Supervising Authorized Username: | | | |

Path Three: Alternative Standard

Submit documentation of the training and experience of the prospective Authorized User physician for review on a case-by-case basis.

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 a 1-year residency in radiation therapy approved by the Residency Review Committee for Radiology of the Accreditation Council for Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association and an additional 2 years of full-time work experience; has training and experience that includes examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment, and any limitations/contraindication; selecting proper dose and how it is to be administered; calculating the external beam radiation therapy doses and collaborating with the authorized user in the review of patients' progress and consideration of the need to modify originally prescribed doses and/or treatment plans as warranted by patients' reaction to radiation; and post-administration follow-up and review of case histories.

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: _____

Signature of Applicant for Authorized User

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 at 785-296-1560, email at kdhe.xray@ks.gov or fax at 785-559-4251.

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

Reviewed By:

Date Approved:

Approved

Not Approved

Comments from Reviewer:



Appendix A – Facility List

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|--|
| Facility of Employment: |
| Facility Address: (Street, City, State, ZIP) |

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