RHODE ISLAND RADIATION CONTROL AGENCY

AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST, TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION

[216-RICR-40-20-9.5.11]

Name of Proposed Authorized Medical Physicist	☐ Authorized Medical Physicist ☐ Ophthalmic Physicist (go to Page 4)

Requested Authorization(s) *(check all that apply)*:

☐ § 9.9.1* Ophthalmic use of strontium-90 ☐ § 9.11.1 Gamma stereotactic radiosurgery unit(s)

☐ § 9.11.1 Remote afterloader unit(s) ☐ § 9.11.1 Teletherapy Unit(s)

PART I - TRAINING AND EXPERIENCE *(Select one of the three methods below)*

Note: *Training and Experience, including board certification, must have been obtained within the seven (7) years preceding the date of application or the individual must have obtained related continuing education and experience since the required training and experience was completed. Provide dates, duration, and description of continuing education and experience related to the uses checked above.*

☐ ***AUTHORIZED MEDICAL PHYSICIST***

☐ **1. Board Certification**

a. Provide a copy of the board certification.

b. If the board certification process has been recognized by the Agency under § 9.5.11 of the Agency regulations, the NRC under 10 CFR 35.51 or under the equivalent regulations of another Agreement State:

i. Go to the table in 3.c. and describe training provider and dates of training for each type of use for which authorization is sought

ii. Stop here

c. If the board certification was issued on or before 24 October 2005 and is listed in § 9.5.13 of the Agency regulations or in 10 CFR 35.57(a)(3), attach:

i. Documentation that the individual performed each use checked above on or before 24 October 2005.

ii. Dates, duration, and description of continuing education and experience within the past seven (7) years for each use checked above.

iii. Stop here

☐ **2. Current Authorized Medical Physicist Seeking Additional Authorization for Use(s) Checked Above**

a. Go to the table in Section 3c to document training for new device.

b. If not board certified, skip to and complete Part II Preceptor Attestation.

c. If board certified, provide a copy of the certificate and stop here.

☐ **3. Education, Training, and Experience for Proposed Authorized Medical Physicist**

a. Education: Document master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university.

Degree	Major Field	College or University

b. Supervised Full-Time Medical Physics Training and Work Experience in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services.

☐ Yes. Completed 1 year of full-time training in medical physics (for areas identified below) under supervision of _____ who meets the requirements for an Authorized Medical Physicist.

AND

☐ Yes. Completed 1 year of full-time work experience in medical physics (for areas identified below) under the supervision of _____ who meets the requirements for an Authorized Medical Physicist

RHODE ISLAND RADIATION CONTROL AGENCY

AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST, TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION [continued]

3. Education, Training, and Experience for Proposed Authorized Medical Physicist [continued]

b. Supervised Full-Time Medical Physics Training and Work Experience [continued]

(*If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page*.)

Description of Training/Experience	Location of Training/License or Permit Number of Training Facility/Medical Devices Used+	Dates of Training*	Dates of Work Experience*
Medical Physics			
Performing sealed source leak tests and inventories			
Performing decay corrections			
Performing full calibration and periodic spot checks of external beam treatment unit(s)			
Performing full calibration and periodic spot checks of stereotactic radiosurgery unit(s)			
Performing full calibration and periodic spot checks of remote afterloading unit(s)			
Conducting radiation surveys around external beam treatment unit(s), stereotactic radiosurgery unit(s), remote after loading unit(s)			

Supervising Individual**	License/Permit Number listing supervising individual as an Authorized Medical Physicist

for the following types of use:

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

+ *Training and work experience must be conducted in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services.*

* *1 year of full-time medical physics training and 1 year of full time work experience cannot be concurrent*.

** *If the supervising medical physicist is not an authorized medical physicist, the licensee must submit evidence that the supervising medical physicist meets the training and experience requirements in § 9.5.11 and § 9.5.14 for the types of use for which the individual is seeking authorization*.

RHODE ISLAND RADIATION CONTROL AGENCY

AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST, TRAINING EXPERIENCE AND PRECEPTOR ATTESTATION [continued]

3. Structured Educational Program for Proposed Authorized Medical Physicist [continued]

c. Describe training provider and dates of training for each type of use for which authorization is sought.

Description of Training	**Training Provider and Dates**		
	Remote Afterloader	**Teletherapy**	**Gamma Stereotactic Radiosurgery**
Hands-on device operation			
Safety procedures for the device use			
Clinical use of the device			
Treatment planning system operation			

Supervising Individual‡	**License/Permit Number listing supervising individual as an Authorized Medical Physicist**

‡*If training was provided by supervising Medical Physicist. (If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

For the following types of use:

☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s) ☐ Remote afterloader unit(s)

Authorization Sought	**Device**	**Training Provided By**	**Dates of Training**
§ 9.9.1 Ophthalmic Use of strontium-90			

d. Skip to and complete Part II Preceptor Attestation

RHODE ISLAND RADIATION CONTROL AGENCY

AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST, TRAINING EXPERIENCE AND PRECEPTOR ATTESTATION [continued]

4. Education, Training, and Experience for Proposed Ophthalmic Physicist

a. Complete the table below to document education.

Degree	Major Field	College or University

b. Supervised Full-Time practical training and experience in medical physics

☐ Yes. Completed 1 year of full-time training in medical physics under the supervision of _____ medical physicist at

_____

AND

☐ Yes. Completed 1 additional year of full-time work experience in medical physics at

_____

under the supervision of _____ medical physicist

If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page

c. Complete the table below to document training and supervised work experience.

Description of Training	Location of Training/License or Permit Number ofTraining Facility	Dates of Training*
The creating, modifying, and completing written directives.		
Procedures for administrations requiring a written directive		
Performing the calibration measurements of brachytherapy sources as detailed in § 9.9.6 of the Agency regulations		

Supervising Individual	License/Permit Number

d. Stop here

RHODE ISLAND RADIATION CONTROL AGENCY

AUTHORIZED MEDICAL PHYSICIST OR OPTHALMIC PHYSICIST, TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION [continued]

PART II - 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.*

First Section
Complete the following:

☐ I attest that _____ has satisfactorily completed the 1-year of full-time
Name of Proposed Authorized Medical Physicist

training in medical physics and an additional year of full-time work experience as required by § 9.5.11 of the Agency regulations.

AND

Second Section
Complete the following:

☐ I attest that _____
Name of Proposed Authorized Medical Physicist

has training for the types of use for which authorization is sought that include hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system.

AND

Third Section
Complete the following:

☐ I attest that _____ is able to independently fulfill the radiation safety-related
Name of Proposed Authorized Medical Physicist

as an Authorized Medical Physicist for the following:

☐ § 9.9.1 Ophthalmic use of strontium-90 ☐ § 9.11.1 Teletherapy unit(s)
☐ § 9.11.1 Remote afterloader unit(s) ☐ § 9.11.1 Gamma stereotactic radiosurgery unit(s)

AND

Fourth Section
Complete the following for preceptor attestation and signature:

☐ I meet the requirements in § 9.5.11, or equivalent NRC/other Agreement State requirements for Authorized Medical Physicist for the following:

☐ § 9.9.1 Ophthalmic use of strontium-90 ☐ § 9.11.1 Teletherapy unit(s)
☐ § 9.11.1 Remote afterloader unit(s) ☐ § 9.11.1 Gamma stereotactic radiosurgery unit(s)

Name of Preceptor	Signature	Telephone Number	Date

License/Permit Number/Facility Name