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

State Form ##### (08-24)
INDIANA DEPARTMENT OF HOMELAND SECURTY

INDIANA DEPARTMENT OF HOMELAND SECURITY
RADIOACTIVE MATERIALS CONTROL PROGRAM
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1. REQUESTED AUTHORIZATIONS

Name of Individual	☐ Authorized Medical Physicist ☐ Ophthalmic Physicist (go to section 3)	
Requested Authorization(s) (check all that apply)	☐ 35.400 Ophthalmic use of Strontium-90 ☐ 35.600 Remote afterloader unit(s)	☐ 35.600 Teletherapy Unit(s) ☐ 35.600 Gamma stereotactic radiosurgery unit(s)

2. TRAINING AND EXPERIENCE (AUTHORIZED MEDICAL PHYSICIST)
(select one of the 3 methods below)

Training and Experience, including Board Certification, must have been obtained within the 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.

☐ 1. Board Certification

a. Provide a copy of board certification.
b. If the board certification process has been recognized by the State, the NRC, or another Agreement State under 10 CFR 35.51:
   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 October 24, 2005 and is listed in 10 CFR 35.57(a)(3), attach:
   i. Documentation that the individual performed each use checked above on or before October 24,2005.
   ii. Dates, duration, and description of continuing education and experience within the past seven 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 3.c. to document training for new device.
b. If board certified, provide a copy of the certificate and stop here.
c. If listed on a license or a permit before January 14, 2019 as an authorized medical physicist, stop here.
d. If not board certified skip to and complete section 4 Preceptor Attestation.

☐ 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 the supervision of

_____ who meets the requirements for an Authorized Medical Physics.

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 Physics.

c. Supervised Full-Time Medical Physics Training and Work Experience. 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/Meical Device(s) 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 10 CFR 35.51 and 35.59 for the types of use for which the individual is seeking authorization.

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

Authorization Sought	Device	Training Provided By	Dates of Training
35.400 Ophthalmic Use of Strontium-90			

e. Skip to and complete section 4 Preceptor Attestation.

3. TRAINING AND EXPERIENCE (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 practical training and experience in medical physics under the supervision of

_____ medical physicist, at _____

AND

☐ Yes. Completed 1 ADDITIONAL year of full-time work experience in medical physics under the supervision of

_____ medical physicist, at _____

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 of Training 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 10 CFR 35.432		
Supervising Individual	License/Permit Number	

d. Stop here.

4. 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 training in medical physics and an additional year of full-time work experience as required by 10 CFR 35.51(b)(1)

AND

Second Section
Complete the following:

☐ I attest that _____ 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 duties as an Authorized Medical Physicist for the following:

☐ 35.400 Ophthalmic use of Strontium-90
☐ 35.600 Remote afterloader unit(s)
☐ 35.600 Teletherapy Unit(s)
☐ 35.600 Gamma stereotactic radiosurgery unit(s)

AND

Fourth Section
Complete the following:

☐ I meet the requirements in 10 CFR 35.51, 35.57, or equivalent Agreement State requirements for Authorized medical physicist for the following:

☐ 35.400 Ophthalmic use of Strontium-90
☐ 35.600 Remote afterloader unit(s)
☐ 35.600 Teletherapy Unit(s)
☐ 35.600 Gamma stereotactic radiosurgery unit(s)

Name of Facility	License/Permit Number	
Name of Preceptor (Typed or Printed)	Telephone Number	Date
Signature		