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| training, experience and preceptor ATTESTATION - D(Authorized User For Manual Brachytherapy Sources) |
| The Wisconsin Department of Health Services is requesting disclosure of all information on this statement for the purpose of authorizing an individual to work with radioactive material. Failure to provide any information may result in denial or delay of authorizing an individual to work with radioactive material. For authorized user of manual brachytherapy sources (HFS 157.65(1)). |
| Instructions: Complete all applicable items. Refer to WISREG “Guidance for Medical Use of Radioactive Material.” Use supplementary sheets where necessary. Retain one copy and submit original of the document to the State of Wisconsin, DHS, Radiation Protection Section, P.O. Box 2659, Madison, WI 53701-2659. |
| **PART I TRAINING AND EXPERIENCE** |
| Describe training and experience in sufficient detail to match the training and experience criteria in applicable regulations. |
| 1. **Name of Individual**

       |
| 1. **State Licensure**

 [ ]  A copy of license to practice medicine in Wisconsin is attached. |
| Certification (attach copy of current certificate) |
| **Specialty Board** | **Category** | **Month and Year Certified** |
|       |       |            |
| Note: Items 4-8 do not need to be completed when using Board Certification to meet Wis. Admin. Code DHS 157 Subchapter VI training and experience requirements.Note: Items 4-6 do not need to be completed for individuals requesting authorization for ophthalmic use only. |
| 1. **Classroom and Laboratory Training**
 |
| **Description of Training** | **Location** | **Dates and Clock Hours of Training** |
| **Radiation Physics and Instrumentation** |           ,         -     |            |
| **Radiation Protection** |           ,         -     |            |
| **Mathematics Pertaining to Use and Measurement of Radioactivity**  |           ,         -     |            |
| **Radiation Biology** |           ,         -     |            |
| 5. Supervised Work Experience  |
| **Description of Experience** | **Location**  | **Dates and Clock Hours of Experience**  |
| **Ordering, Receiving and Unpacking Radioactive Materials**  |           ,         -     |            |
| **Checking Survey Meters for Proper Operation and Performing Radiation Surveys** |           ,         -     |            |
| **Preparing, Implanting and Removing Brachytherapy Sources** |           ,         -     |            |
| **Maintaining Running Inventories of Licensed Material On Hand**  |           ,         -     |            |
| **Using Administrative Controls to Prevent a Medical Event Involving the Use of Radioactive Material** |           ,         -     |            |

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| **6. Supervised Clinical Experience in Radiation Oncology** |
| **Description of Experience** | **Location** | **Dates of Experience** |
|       |           ,         -     |            |
|       |           ,         -     |            |
|       |           ,         -     |            |
|       |           ,         -     |            |
|       |           ,         -     |            |
| **7a. Training and Experience for Ophthalmic Uses of Strontium-90 under DHS 157.65(9)** **[ ]  N/A** |
|  | **Classroom and Laboratory Training for Ophthalmic Uses of Strontium-90** |
| **Description of Experience** | **Location**  | **Dates of Experience**  |
|  | **Radiation Physics and Instrumentation** |           ,         -     |       |
|  | **Radiation Protection** |           ,         -     |       |
|  | **Mathematics pertaining to the Use and Measurement of Radioactivity** |           ,         -     |       |
|  | **Radiation Biology** |           ,         -     |       |
| **7b. Supervised Clinical Training for Ophthalmic Uses of Strontium-90 [ ]  N/A** |
| **Description of Topics** | **Number of Cases Involving Personal Participation** | **Location** | **Dates of Experience** |
|  | **Examination of Each Person to be Treated** |       |           ,         -     |       |
|  | **Calculation of the Dose to be Administered** |       |           ,         -     |       |
|  | **Administration of Dose** |       |           ,         -     |       |
|  | **Follow Up and Review of Each Individual’s Case History** |       |           ,         -     |       |
| **8. Supervising Individual – Identification and Qualifications** |
| If more than one supervising individual is needed to meet requirements in Wisconsin Administrative Code, DHS 157 Subchapter VI, provide the following information for each: |
| [ ]  | Supervisor meets requirements of [ ]  s. DHS 157.65(8) or [ ]  s. DHS 157.65(9) or equivalent NRC or another Agreement State requirements for the type(s) of use for which the individual named in Item 1 is seeking authorization.. |
| Name of Supervising Individual      |
| Name of License on which Supervising Individual is Authorized      | Materials License Number (Indicate which state or if NRC)      |

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| PART II PRECEPTOR ATTESTATION |
| NOTE: | 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.  |
| 9. Preceptor Approval and Attestation |
| [ ]  | I meet DHS requirements to be a preceptor authorized user for the type(s) of use for which the individual named in Item 1 is seeking authorization. |
| [ ]  **N/A** | **Manual Brachytherapy**  |
|  I attest that the individual named in number 1 has: |
| [ ]  | satisfactorily completed the training requirements in s. DHS 157.65(8)  |
|  |  AND |
| [ ]  | achieved a level of competency sufficient to function independently as an authorized user of manual brachytherapy sources for the medical uses authorized under s. DHS 157.65(1). |
| **[ ]  N/A** | **Ophthalmic Uses of Strontium-90**  |
|  I attest that the individual named in number 1 has: |
| **[ ]**  | satisfactorily completed the training requirements in [ ]  s. DHS 157.65(8) or [ ]  s. DHS 157.65(9) |
|  |  AND |
| **[ ]**  | achieved a level of competency sufficient to function independently as an authorized user of strontium-90 for ophthalmic use. |
| Name of License on which Preceptor is Authorized      | Materials License Number (Indicate which state or if NRC)      |
| Print Name of Preceptor      |
| SIGNATURE – Preceptor | Date Signed      |