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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-45010G (Rev. 07/08) | **STATE OF WISCONSIN**Bureau of Environmental HealthRadiation Protection Section608-267-4797 |

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| training, experience and preceptor ATTESTATION - G(Authorized Medical Physicist) |
| 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 Medical Physicist. |
| Instructions: Complete all applicable items. Refer to WISREG-1556, Volume 9, “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, Department of Health Services, 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. **Authorization requested (e.g., Sr-90 ophthalmic use, gamma knife, HDR):**

      |
| Certification (attach copy of current certificate) |
| **Specialty Board** | **Category** | **Month and Year Certified** |
|       |       |            |
| Note: Items 4-6 do not need to be completed when using Board Certification to meet Wis. Admin. Code DHS 157 Subchapter VI training and experience requirements. |
| 1. **Formal Training**
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| **Degree and Area of Study** | **Name and Location of Program with Corresponding Materials License Number** | **Dates** |
|            |                ,         -     |       |
| 5. Supervised Work Experience |
| **Description of Experience** | **Dates of Experience**  | **Description of Experience** | **Dates of Experience** |
| **Performing sealed source leak tests and inventories** |       | **Hands-on device operation** |       |
| **Performing decay corrections** |       | **Safety procedures** |       |
| **Performing full calibration and periodic spot checks** |       | **Clinical use** |       |
| **Conducting radiation surveys** |       | **Operation of a treatment planning system** |       |

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| 1. **Supervising Individual – Identification and Qualifications**
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| 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 the requirements of s. DHS 157.61(8) or (10) or equivalent NRC or another Agreement State requirements for the type(s) of use for which the person 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)      |
| **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.  |
| 7. Preceptor Approval and Attestation[ ]  I am an authorized medical physicist authorized for the type(s) of use for which the individual named in Item 1 is seeking authorized medical physicist status. |
| I attest that the individual named in Item 1: |
| **[ ]**  | Has satisfactorily completed the training requirements in s. DHS 157.61(8).  |
|  |  AND |
| **[ ]**  | Has achieved a level of competency sufficient to independently function as an authorized medical physicist for each type of therapeutic medical unit for which the individual is requesting authorized medical physicist status. |
| 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 |