



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RADIOLOGICAL HEALTH SECTION

AUTHORIZED MEDICAL PHYSICIST TRAINING AND EXPERIENCE
AND PRECEPTOR ATTESTATION

(New Hampshire Rules for the Control of Radiation He-P 4035.70)

Name of Proposed Authorized Medical Physicist:

REQUESTED AUTHORIZATION(S) - Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> 4035.67 Ophthalmic Use of Strontium-90 | <input type="checkbox"/> 4035.47 Gamma Stereotactic Radiosurgery Unit(s) |
| <input type="checkbox"/> 4035.47 Remote Afterloader Unit(s) | <input type="checkbox"/> 4035.47 Teletherapy Unit(s) |

PART I – TRAINING AND EXPERIENCE
(He-P 4035.70)

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

1. **Board Certification**

- a. Provide a copy of the board certification.
- b. Use the table in section 3.c. to describe training provider and dates of training for each type of use for which authorization is sought.
- c. Skip to and complete Part II Preceptor Attestation.

OR

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

- a. Use the table in section 3.c. to document training for new device.
- b. Skip to and complete Part II Preceptor Attestation.

OR

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 Physicist for the type(s) of use for which the individual is seeking authorization.

AND

- Yes. Completed additional 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 for the type(s) of use for which the individual is seeking authorization..

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 afterloading unit(s)			

Supervising Individual**

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

for the following types of use: Ophthalmic use of strontium-90 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 He-P 4035.70 and 4035.73 for the types of use for which the individual is seeking authorization.

3. Education, Training, and Experience 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 – <i>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.)</i>		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)

If applicable:

Authorization Sought	Device	Training Provided By	Dates of Training
He-P 4035.67 Ophthalmic use of strontium-90			

d. Complete Part II Preceptor Attestation

PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual’s preceptor. The authorized medical physicist 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 authorized medical physicist preceptor is necessary to document experience, obtain a separate preceptor statement from each.

FIRST SECTION – Check one of the following:

1. Board Certification

I attest that _____ has satisfactorily completed the requirements in
Name of Proposed Authorized Medical Physicist
He-P 4035.70(a), (b)(1) and (b)(2)a.; or 4035.70(a), (b)(1) and (b)(2)b.

OR

2. Education, Training, and Experience

I attest that _____ has satisfactorily completed the training and experience
Name of Proposed Authorized Medical Physicist
as required by He-P 4035.70(b)(3) and (b)(4).

AND

SECOND SECTION – Complete for all submittals.

I attest that _____ has training for the types of use for which authorization
Name of Proposed Authorized Medical Physicist

is sought that includes hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system. Furthermore, this individual has achieved a level of competency sufficient to function as an Authorized Medical Physicist for the following:

- | | |
|---|--|
| <input type="checkbox"/> 4035.41 Ophthalmic Use of Strontium-90 | <input type="checkbox"/> 4035.47 Gamma Stereotactic Radiosurgery Unit(s) |
| <input type="checkbox"/> 4035.47 Remote Afterloader Unit(s) | <input type="checkbox"/> 4035.47 Teletherapy Unit(s) |

AND

THIRD SECTION – Complete for all submittals.

I meet the requirements in He-P 4035.70, or equivalent U.S. Nuclear Regulatory Commission or Agreement State requirements, for Authorized Medical Physicist for the following:

- | | |
|---|--|
| <input type="checkbox"/> 4035.67 Ophthalmic Use of Strontium-90 | <input type="checkbox"/> 4035.59 Gamma Stereotactic Radiosurgery Unit(s) |
| <input type="checkbox"/> 4035.59 Remote Afterloader Unit(s) | <input type="checkbox"/> 4035.59 Teletherapy Unit(s) |

Name of Preceptor:	Telephone Number:
Signature:	Date:
License/Permit Number/Facility Name:	