FORM DHHS/RHS-1M
Supplement B-Sources

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

AUTHORIZED USER TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION

(New Hampshire Rules for the Control of Radiation He-P 4035.59, 4035.67, 4035.69 & 4035.71)

Name of Proposed Authorized User	**State or Territory Where Licensed**

Requested Authorized Use(s) – *Check all that apply:*

- ☐ He-P 4035.41 Manual brachytherapy sources
- ☐ He-P 4035.41 Ophthalmic use of strontium-90
- ☐ He-P 4035.47 Remote afterloader unit(s)
- ☐ He-P 4035.47 Teletherapy unit(s)
- ☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)

PART I – TRAINING AND EXPERIENCE
(He-P 4035.59, 4035.67, 4035.69 and 4035.71)

* 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. <u>Board Certification</u>**

a. Provide a copy of the board certification.

b. For He-P 4035.59, go to the table in 3.a. and describe training provider and dates of training for each type of use for which authorization is sought.

c. If the board certification was issued on or before October 24, 2005 and is listed in He-P 4035.71; provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005 and is compliant with He-P 4035.73.

d. **STOP** here.

OR

☐ **2. <u>Current He-P 4035.47 Authorized User Seeking Additional Authorization for He-P 4035.47 Use(s) Checked Above</u>**

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

b. If board certified, provide a copy and **STOP** here. If not, skip to and complete Part II Preceptor Attestation.

OR

☐ **3. <u>Training and Experience for Proposed Authorized User</u>**

a. For He-P 4035.47 uses, describe training provider and dates of training for each type of authorized use requested.

Description of Training	**Training Provider and Dates**		
	Remote Afterloader	**Teletherapy**	**Gamma Stereotactic Radiosurgery**
Device operation			
Safety procedures for the device use			
Clinical use of the device			

Supervising Individual – *If training was provided by Supervising Individual. (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 user**

Authorized for the following types of use:

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

3. Training and Experience for Proposed Authorized User (continued)

b. Classroom & Laboratory Training (*Check all that apply):* ☐ He-P 4035.59 ☐ He-P 4035.67 ☐ He-P 4035.69

Description of Training	Location of Training	No. of Hours	Dates of Training*
Radiation physics and instrumentation			
Radiation protection			
Mathematics pertaining to the use and measurement of radioactivity			
Radiation biology			

Total Hours of Training _____

c. Supervised Work & Clinical Experience for He-P 4035.59 **Total Hours of Experience** _____

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

Description of Experience Must Include	Location of Experience/ License or Permit Number of Facility	Confirm	Dates of Experience*
Reviewing full calibration measurements and periodic spot-checks		☐ Yes ☐ No	
Preparing treatment plans and calculating treatment doses and times		☐ Yes ☐ No	
Using administrative controls to prevent a medical event involving the use of byproduct material		☐ Yes ☐ No	
Implementing emergency procedures to be followed in the event of an abnormal operation of the medical unit or console		☐ Yes ☐ No	
Checking and using survey meters		☐ Yes ☐ No	
Selecting the proper dose and how it is to be administered		☐ Yes ☐ No	

Clinical experience in radiation oncology as part of an approved formal training program	Location of Experience/ License or Permit Number of Facility	Dates of Experience*
Approved by: ☐ Residency Review Committee for Radiation Oncology of the ACGME ☐ Royal College of Physicians and Surgeons of Canada ☐ Council on Postdoctoral Training of the American Osteopathic Association		

Supervising Individual	License/Permit number listing supervising individual as an authorized user

3. Training and Experience for Proposed Authorized User (continued)

d. Supervised Clinical Experience He-P 4035.67

Description of Experience	Location of Experience/License or Permit Number of Facility	No. of Hours	Dates of Experience*
Use of strontium-90 for ophthalmic treatment, including: Examination of each individual to be treated; Calculation of the dose to be administered; Administration of the dose; and Follow up and review of each individual's case history			

Supervising Individual	License/Permit number listing supervising individual as an authorized user

e. Supervised Work and Clinical Experience for He-P 4035.69 **Total Hours of Experience** _____

(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)

Description of Experience Must Include	Location of Experience/ License or Permit Number of Facility	Confirm	Dates of Experience*
Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys		☐ Yes ☐ No	
Checking survey meters for proper operation		☐ Yes ☐ No	
Preparing, implanting, and safely removing brachytherapy sources		☐ Yes ☐ No	
Maintaining running inventories of material on hand		☐ Yes ☐ No	
Using administrative controls to prevent a medical event involving the use of byproduct material		☐ Yes ☐ No	
Using emergency procedures to control byproduct material		☐ Yes ☐ No	

Clinical experience in radiation oncology as part of an approved formal training program	Location of Experience/ License or Permit Number of Facility	Dates of Experience*
Approved by: ☐ Residency Review Committee for Radiation Oncology of the ACGME ☐ Royal College of Physicians and Surgeons of Canada ☐ Council on Postdoctoral Training of the American Osteopathic Association		

Supervising Individual	License/Permit number listing supervising individual as an authorized user

f. Complete Part II Preceptor Attestation.

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.

By checking the boxes below, the preceptor is attesting that the individual has knowledge to fulfill the duties of the position sought and not attesting to the individual's "general clinical competency."

FIRST SECTION – Check one of the following for each requested authorization:

For He-P 4035.59

☐ I attest that _____ has satisfactorily completed the training, supervised work
Name of Proposed Authorized User

experience and 3 years of supervised clinical experience in radiation therapy as required by He-P 4035.59(b).

AND

☐ I attest that _____ has received training required in He-P 4035.59(c) for device
Name of Proposed Authorized User

operation, safety procedures, and clinical use for the type(s) of use for which authorization is sought, as checked below.

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

For He-P 4035.67

☐ I attest that _____ has satisfactorily completed the classroom and laboratory
Name of Proposed Authorized User

training and the supervised clinical training, which includes the use of strontium-90 for the ophthalmic treatment of 5 individuals, as required by He-P 4035.67 for the ophthalmic use of strontium-90.

For He-P 4035.69

☐ I attest that _____ has satisfactorily completed the training, supervised work
Name of Proposed Authorized User

experience and 3 years of supervised clinical experience in radiation oncology as required by He-P 4035.69(b) for the medical use of manual brachytherapy sources.

AND

SECOND SECTION

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

duties as an authorized user for the authorized use requested: *(Check all that apply)*

☐ He-P 4035.41 Manual brachytherapy sources

☐ He-P 4035.41 Ophthalmic use of strontium-90

☐ He-P 4035.47 Remote afterloader unit(s)

☐ He-P 4035.47 Teletherapy unit(s)

☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)

THIRD SECTION

Authorized User

☐ I meet the requirements in He-P 4035.59, 4035.67, 4035.69 or equivalent NRC or Agreement State requirements as an authorized user for the following:

- ☐ He-P 4035.41 Manual brachytherapy sources
- ☐ He-P 4035.41 Ophthalmic use of strontium-90
- ☐ He-P 4035.47 Remote afterloader unit(s)
- ☐ He-P 4035.47 Teletherapy unit(s)
- ☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)
- ☐ He-P 4035.71 for He-P 4035.41 and/or 4035.47 uses, as applicable

OR

Residency Program Director (for He-P 4035.59 and/or 4035.69 only)

☐ I affirm that the attestation represents the consensus of the residency program faculty where at least one faculty member is an authorized user who meets the following requirements or equivalent NRC or Agreement State requirements:

- ☐ He-P 4035.41 Manual brachytherapy sources
- ☐ He-P 4035.47 Remote afterloader unit(s)
- ☐ He-P 4035.47 Teletherapy unit(s)
- ☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)
- ☐ He-P 4035.71 for He-P 4035.41 and/or 4035.47 uses, as applicable

☐ I affirm that this facility member concurs with the attestation I am providing as program director.

☐ I affirm that the residency training program is approved by the:

- ☐ Residency Review Committee of the Accreditation Council for Graduate Medical Education; or
- ☐ Royal College of Physicians and Surgeons of Canada; or
- ☐ Council on Post-Graduate Training of the American Osteopathic Association.

☐ I affirm that the residency training program includes training & experience specified in: ☐ He-P 4035.59 ☐ He-P 4035.69

Name of Preceptor	**Signature**	**Telephone Number**	**Date**

Facility Name **License/Permit Number**