



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

AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST
TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION
(New Hampshire Rules for the Control of Radiation He-P 4035.70 or He-P 4035.32)

Name of Proposed Authorized Physicist:

- Authorized Medical Physicist
 Ophthalmic Physicist

REQUESTED AUTHORIZED USE(S) - Check all that apply:

- 4035.41 Ophthalmic Use of Strontium-90 4035.47 Gamma Stereotactic Radiosurgery Unit(s)
 4035.47 Remote Afterloader Unit(s) 4035.47 Teletherapy Unit(s)

PART I – TRAINING AND EXPERIENCE
(He-P 4035.32, He-P 4035.70, He-P 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. For Ophthalmic Physicist, skip to and complete page C4.

1. Board Certification for Proposed Authorized Medical Physicist

- a. Provide a copy of the board certification.
- b. (i) If the board certification process has been recognized by the U.S. Nuclear Regulatory Commission (NRC) and meets the requirements of He-P 4035.70, then 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.
- (ii) If board certification was issued on or before October 24, 2005 & is listed in He-P 4035.71(a)(3); provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005, and dates, duration and description of continuing education/experience within the past 7 years for each use requested.
- c. **STOP** here. **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. If not board certified, skip to and complete Part II Preceptor Attestation.
- c. If board certified, provide a copy of the certificate and **STOP** here.

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, as required by He-P 4035.70(b):

- 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

- Completed an additional 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 ^x	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, stereotactic radiosurgery, and/or remote afterloading unit(s)			

Supervising Individual**	License/Permit Number listing supervising individual
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for the following types of use:

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

^x 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 individual is a medical physicist that 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** – (If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)		License/Permit number listing supervising individual	

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 4035.32 Ophthalmic use of Strontium-90			

d. Skip to and complete Part II Preceptor Attestation

OPHTHALMIC PHYSICIST

Education, Training and Experience for Proposed Ophthalmic 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 practical training and work experience in Medical Physics, as required by He-P 4035.32(f):

Completed 1 year of full-time training in medical physics at

under the supervision of _____ Medical Physicist.

AND

Completed an additional year of full-time work experience in medical physics at

under the supervision of _____ Medical Physicist.

(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*
Creating, modifying and completing written directives.		
Procedures for administrations requiring a written directive.		
Performing the calibration measurements of brachytherapy sources as detailed in He-P 4035.46.		
Supervising Individual		License/Permit number listing supervising individual

d. **STOP** here.

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

I attest that _____ has satisfactorily completed the 1 year of full-time training and an additional year of full-time work experience in medical physics, as required by He-P 4035.70(b).
Name of Proposed Authorized Medical Physicist

AND

SECOND SECTION

I attest that _____ has training for the types of use for which authorization is sought that includes hands-on device operation, safety procedures, clinical use and the operation of a treatment planning system.
Name of Proposed Authorized Medical Physicist

AND

THIRD SECTION

I attest that _____ is able to independently fulfill the radiation safety-related duties as an Authorized Medical Physicist for the following:
Name of Proposed Authorized Medical Physicist

4035.41 Ophthalmic Use of Strontium-90 4035.47 Gamma Stereotactic Radiosurgery Unit(s)
 4035.47 Remote Afterloader Unit(s) 4035.47 Teletherapy Unit(s)

AND

FOURTH SECTION

I meet the requirements in He-P 4035.70, He-P 4035.71 or equivalent NRC or Agreement State requirements, for an Authorized Medical Physicist for the following:

4035.41 Ophthalmic Use of Strontium-90 4035.47 Gamma Stereotactic Radiosurgery Unit(s)
 4035.47 Remote Afterloader Unit(s) 4035.47 Teletherapy Unit(s)

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