AUTHORIZED USER TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION (for uses defined under 35.400 and 35.600) [10 CFR 35.57, 35.490, 35.491, and 35.690]

State Form 9900460 (R0 / 9-26)

INDIANA DEPARTMENT OF HOMELAND SECURITY
RADIOACTIVE MATERIALS CONTROL PROGRAM
302 West Washington Street, Room E208
Indianapolis, IN 46204
Telephone: (317) 232-2222
E-mail: RMCP@dhs.IN.gov
Website: www.dhs.in.gov

1. REQUESTED AUTHORIZATIONS

Name of Proposed Authorized User	State or Territory where Licensed

Requested Authorization(s) (*check all that apply*)

- ☐ 35.400 Ophthalmic use of Strontium-90
- ☐ 35.400 Manual Brachytherapy Sources
- ☐ 35.600 Remote Afterloader Unit(s)
- ☐ 35.600 Teletherapy Unit(s)
- ☐ 35.600 Gamma Stereotactic Radiosurgery Unit(s)

2. TRAINING AND EXPERIENCE (*SELECT ONE OF THE METHODS BELOW*)

Training and Experience, including Board Certification, must have been obtained within the 7 years preceding the date of application or the individual must have obtained related continuing education and experience since the required training and experience was completed. Provide dates, duration, and description of continuing education and experience related to the uses checked above.

☐ 1. Board Certification
- a. Provide a copy of the board certification.
- b. For 35.690, go to the table in 3.e. and describe training provider and dates of training for each type of use for which authorization is sought.
- c. For a board certification issued on or before October 24, 2005, that is listed in 10 CFR 35.57(b)(2)(iii), provide the following:
  - i. Documentation that the individual performed each use checked above on or before October 24, 2005.
  - ii. Dates, duration, and description of continuing education and experience within the past seven years for each use checked above.
- d. Stop here.

☐ 2. Current 35.600 Authorized User Requesting Additional Authorization for 35.600 Use(s) Checked Above
- a. Go to the table in section 3.e. to document training for new device.
- b. If board certified, provide a copy of the certificate and stop here. If not board certified, provide completed Part 3 Preceptor Attestation.

☐ 3. Training and Experience for Proposed Authorized User

a. ☐ 35.490 ☐ 35.491 ☐ 35.690

Description of Training	Location of Training	Clock Hours	Dates of Training
Radiation Physics and Instrumentation			
Radiation Protection			
Mathematics Pertaining to the Use and Measurement of Radioactivity			
Chemistry of byproduct material for medical use (not required for 35.590)			
Radiation Biology			
Total Hours of Training:			

b. Supervised Work and Clinical Experience for 10 CFR 35.490 (If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this page.)

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 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	
Total Hours of Experience:			

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 of Postdoctoral Training of the American Osteopathic Association		
Supervising Individual	License/Permit Number listing supervising individual as an Authorized User	

c. Supervised Clinical Experience for 10 CFR 35.491

Description of Experience	Location of Experience/License or Permit Number of Facility	Clock 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	

d. Supervised Work and Clinical Experience for 10 CFR 35.690

☐ 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 the 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	
Total Hours of Experience:			

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 of Postdoctoral Training of the American Osteopathic Association		
Supervising Individual	License/Permit Number listing supervising individual as an Authorized User	

e. For 35.600, 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
Device operation			
Safety procedures for the device use			
Clinical use of the device			

Supervising individual (If training is provided by Supervising Medical Physicist, (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 Medical Physicist

For the following types of use:

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

3. 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.

First Section
Check one of the following for each requested authorization:

For 35.490:

☐ I attest that _____ has satisfactorily completed the 200 hours of classroom and laboratory training. 500 hours of supervised work experience, and 3 years of supervised clinical experience in radiation oncology, as required by 10 CFR 35.490(b)(1) and (b)(2), and is able to independently fulfill the radiation safety-related duties as ana authorized user of manual brachytherapy sources for the medical uses authorized under 10 CFR 35.400.

For 35.491:

☐ I attest that _____ has satisfactorily completed the 24 hours of classroom and laboratory training applicable to the medical use of strontium-90 for ophthalmic radiotherapy, has used strontium-90 for ophthalmic treatment of 5 individuals, as required by 10 CFR 35.491(b), and is able to independently fulfill the radiation safety-related duties as an authorized user of strontium-90 for ophthalmic use.

Second Section

For 35.690:

☐ I attest that _____ has satisfactorily completed the 200 hours of classroom and laboratory training. 500 hours of supervised work experience, and 3 years of supervised clinical experience in radiation oncology, as required by 10 CFR 35.690(b)(1) and (b)(2).

AND

Third Section

For 35.690: (continued)

☐ I attest that _____ has received training required in 35.690(c) for device 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)

AND

Fourth Section

☐ I attest that _____ is able to independently fulfill the radiation safety-related duties as an authorized user for

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

Fifth Section
Complete one of the following for attestation and signature.

☐ Authorized User

☐ I meet the requirements in 10 CFR 35.490, 35.491, 35.690, or equivalent Agreement State requirements, as an authorized user for:

☐ 35.400 Manual brachytherapy unit(s)
☐ 35.400 Ophthalmic use of strontium-90
☐ 35.600 Remote afterloader unit(s)
☐ 35.600 Teletherapy unit(s)
☐ 35.600 Gamma stereotactic radiosurgery unit(s)
☐ 35.57 for 35.400 and/or 35.600 uses as applicable

OR

☐ Residency Program Director (For 35.490 and/or 35.690 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 requirements below or equivalent Agreement State requirements for:

☐ 35.400 Manual brachytherapy unit(s)
☐ 35.600 Teletherapy unit(s)
☐ 35.600 Remote afterloader unit(s)
☐ 35.600 Gamma stereotactic radiosurgery unit(s)
☐ 35.57 for 35.400 uses
☐ 35.57 for teletherapy unit(s)
☐ 35.57 for remote afterloader unit(s)
☐ 35.57 for gamma stereotactic radiosurgery unit(s)

☐ I affirm that this faculty 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

☐ Royal College of Physicians and Surgeons of Canada

☐ Council of Postdoctoral Training of the American Osteopathic Association

☐ I affirm that the residency training program includes training and experience in:

☐ 35.490 ☐ 35.690

Name of Facility:			
License/Permit Number:			
Name of Preceptor or Residency Program Director (Typed or printed)		Telephone Number	Date
Signature			