



Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

## REGISTRATION FOR MEDICAL DIAGNOSTIC X-RAY PHYSICIST AND/OR RADIATION THERAPY PHYSICIST

I would like to be considered as **(check all that apply):**

MEDICAL DIAGNOSTIC X-RAY PHYSICIST

RADIATION THERAPY PHYSICIST

SECTION I: GENERAL INFORMATION			
FIRST NAME:	LAST NAME:	SUFFIX (Ph.D., MS, BS, Etc.)	
MAILING ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE NUMBER:	CELL PHONE NUMBER:	EMAIL ADDRESS:	
COMPANY NAME OR PRIMARY PLACE OF EMPLOYMENT:			
COMPANY ADDRESS: (STREET, CITY, STATE, ZIP)			
(IF RADIATION THERAPY PHYSICIST) NAME OF FACILITY OF EMPLOYMENT:			

SECTION II: CATEGORIES OF RECOGNITION	<i>(Check applicable Pathway)</i>
<input type="checkbox"/> PATH ONE: NATIONALLY-RECOGNIZED CERTIFYING BODY	
<input type="checkbox"/> PATH TWO: MASTERS/PH.D. DEGREE PLUS TRAINING AND EXPERIENCE	
<input type="checkbox"/> PATH THREE: ALTERNATIVE STANDARD	

PATH ONE: NATIONALLY-RECOGNIZED CERTIFYING BODY	
<u>BOARD CERTIFICATION</u>	<u>AREA OF CERTIFICATION</u>
<input type="checkbox"/> AMERICAN BOARD OF RADIOLOGY (ABR)	<input type="checkbox"/> RADIOLOGICAL PHYSICS
<input type="checkbox"/> AMERICAN BOARD OF MEDICAL PHYSICS (ABMP)	<input type="checkbox"/> DIAGNOSTIC RADIOLOGICAL PHYSICS
<input type="checkbox"/> CANADIAN COLLEGE OF MEDICAL PHYSICS (CCMP)	<input type="checkbox"/> THERAPEUTIC RADIOLOGICAL PHYSICS
<input type="checkbox"/> AMERICAN BOARD OF HEALTH PHYSICS (ABHP)	<input type="checkbox"/> ROENTGEN RAY & GAMMA RAY PHYSICS
<input type="checkbox"/> AMERICAN ACADEMY OF HEALTH PHYSICS (AAHP)	<input type="checkbox"/> X-RAY & RADIUM PHYSICS
<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)
<b><u>ATTACH COPY OF BOARD CERTIFICATION</u></b>	

**PATH TWO: MASTERS/PH.D DEGREE PLUS TRAINING AND EXPERIENCE**

PH.D COLLEGE/UNIVERSITY \_\_\_\_\_

M.S. DATE DEGREE RECEIVED \_\_\_\_\_

**AND**

Minimum of one (1) year full time training and one (1) year full time of professional/clinical work experience under supervision acceptable to the Department.

<b>TRAINING</b>	
Date or Date Range:	
Supervised By (Name):	
Supervisor Address (City, State, Zip):	
Supervisor Phone:	
Supervisor Email:	
Facility/Company and Location:	

<b>PROFESSIONAL/FULL TIME WORK EXPERIENCE UNDER SUPERVISION</b>	
Date or Date Range:	
Supervised By (Name):	
Supervisor Address (City, State, Zip):	
Supervisor Phone:	
Supervisor Email:	
Facility/Company and Location:	

**AND**

**ATTACH DOCUMENTATION/EVIDENCE OF TRAINING AND PROFESSIONAL/FULL TIME WORK EXPERIENCE**

- Copy of Diploma and/or Transcript
- Evidence of Training and Work Experience such as:
  - Detailed description of your experience in Radiation safety including: Facilities, Dates, Supervisors, QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used
  - Supervisor (s) statement describing the nature of the experience and the supervision given. The statement should demonstrate that the supervisor meets the common qualifications of recognition as a Medical Diagnostic X-ray Physicist or Radiation Therapy Physicist.
  - Preceptor Attestation

**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.*

I attest that \_\_\_\_\_ has satisfactorily completed the 1-year of full-time training in  
(Printed Name of person seeking authorization)

medical physics and an additional year of full-time work experience has training and experience that includes hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system; and has achieved a level of competency sufficient to function independently for the types of use for which authorization is sought.

**Complete the following for preceptor attestation and signature:**

As preceptor, I meet the common qualifications of recognition for the types of use for which the above named individual seeks authorization.

Name of Preceptor	Signature
Phone Number	Date
Kansas Registration Number	

**PATH THREE: ALTERNATIVE STANDARD/RECOGNIZED BY PETITION**

I do not meet the qualifications specified in Pathway I or II, above. However, I believe that I am qualified to perform or direct competent and dependable radiation safety surveys and/or consultations in the category (or categories) for which I am applying, as I have relevant educational, professional, clinical or technical experience.

Document(s) Submitted to support Petition for Registered Service Provider Status	Check if enclosed
Detailed description of your Radiation Safety experience including: Facilities; Dates; Supervisors; QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used	<input type="checkbox"/>
Vendor Specific Training Course(s): Type of Equipment; Manufacturer; Model; Etc.	<input type="checkbox"/>
If documentation is other than above, describe separately at length, in detail: <b>Note that the burden of evidence is on the petitioner.</b>	<input type="checkbox"/>

### SECTION III: AREAS OF EXPERTISE

#### Areas of survey specialization for requested recognition of Service Provider Approval

My training and experience as described above has enabled me to perform or direct competent and dependable surveys and/or radiation consultation in the following specialized areas; and I am able to provide specific evidence of both training and experience in the areas indicated upon request.

- 1. HEALTH PHYSICS CONSULTATION
- 2. DIAGNOSTIC RADIOGRAPHIC (MEDICAL/CHIROPRACTIC/PODIATRIC)
- 3. MAMMOGRAPHY (MUST CONFORM TO FEDERAL MQSA STANDARDS)
- 4. FLUOROSCOPY/INTERVENTIONAL RADIOLOGY
- 5. NON-MEDICAL/INDUSTRIAL/ACADEMIC/RESEARCH
- 6. THERAPY/LINEAR ACCELERATOR
- 7. SHIELDING DESIGN
- 8. C.T.
- 9. BONE DENSITY/DEXA
- 10. DENTAL (NON CBCT)
- 11. VETERINARY RADIOLOGY
- 12. OTHER (DESCRIBE BELOW):

---

---

---

---

---

### SECTION IV: AVAILABILITY FOR CONSULTATION

*Please indicate your availability for consultation with Kansas registrants.*

- I am available for radiation safety consultation or surveys with Kansas registrants for a fee.
  
- I would like to be included on the Radiation Control Program webpage as a registered Medical Diagnostic X-ray Physicist and/or Radiation Therapy Physicist in Kansas.  
Contact Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Company Name: \_\_\_\_\_
  
- I would NOT like to be included on the Radiation Control Program webpage as a registered Medical Diagnostic X-ray Physicist and/or Radiation Therapy Physicist in Kansas.
  
- I am NOT available for consulting outside my primary work place and do NOT want to be included on the Radiation Control Program webpage as a registered Medical Diagnostic X-ray Physicist and/or Radiation Therapy Physicist in Kansas

## SECTION V: SIGNATURE

Signature by the applicant below certifies that:

I certify that the information provided on this application is true and accurate, and I give my permission to the Department officials to verify information as needed.

If my contact information changes, I agree to notify KDHE, Bureau of Community Health Systems, Radiation Control Program, 1000 SW Jackson, Suite 330, Topeka, KS 66612-1365 by phone, email or fax.

SIGNATURE	DATE
-----------	------

**Submit this completed form and training certificates to:**

**Kansas Department of Health and Environment**

**Bureau of Community Health Systems**

**Radiation Control Program**

**1000 SW Jackson, Suite 330**

**Topeka, KS 66612-1365**

**Phone: 785-296-1560, Fax: 785-296-0984**

**Email Address: kdhe.xray@ks.gov**

**KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT RADIATION CONTROL PROGRAM USE ONLY**

INITIAL REVIEW BY:	DATE REVIEWED
APPROVED BY:	DATE APPROVED
SERVICE PROVIDER NUMBER ASSIGNED:	NOT APPROVED <input type="checkbox"/>

(Last revised 11/16)

COMMENTS FROM REVIEWER: