

TEXAS DEPARTMENT OF STATE HEALTH SERVICES PRECEPTOR STATEMENT FOR LICENSE APPLICATION

PREPARED FOR CONSIDERATION TO RAM LICENSE NUMBER: _____

Statement must be completed and signed by the physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each. Equivalent forms, including those from other Regulatory Agencies, will be accepted. Print or type.

1. Applicant's Full Name and Address: _____ _____ _____	2. Dates of Training: _____ _____ _____
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CLINICAL TRAINING AND EXPERIENCE OF THE PROPOSED PHYSICIAN USER §289.256(ff) and (hh)

Column A Radionuclide	Column B Conditions Diagnosed or Evaluated	Column C Number of Cases Involving Personal Participation*	Column D Comments
I-125 or I-131 or Co-57 or Co-58	Diagnosis of Thyroid Function		
	Blood Volume or Blood Plasma Volume		
	Liver Function		
	Kidney Function Studies		
	<i>In vitro</i> Studies		
	Schilling Test <i>(other)</i>		
I-125	Detection of Thrombus		
In-111	Labelled WBC for Infection Imaging		
	Cisternogram/Shunt Patency Imaging		
Ga-67	Abscess or Tumor Imaging		
Xe-133	Pulmonary Ventilation/Blood Flood Imaging		
I-123	Thyroid Imaging/Uptake		
TI-201	Cardiac Perfusion Imaging		
Tc-99m	Cardiac Perfusion, E.F., Gated Wall Motion		
	Blood Pool Imaging		
	Bone Imaging		
	Sentinel Node Imaging		
	Breast (Mammoscintigraphy) Imaging		
	Cystography/Ureteral Reflux Imaging		
	Diverticulum Imaging		
	Gastric Emptying and Reflux Imaging		
	GI Bleed Imaging		
	Hepatobiliary Imaging		
	Liver/Spleen and Bone Marrow Imaging		
	Lung Perfusion Imaging		
	Myocardial Infarction Imaging		
	Renal Perfusion/GFR Imaging		
	Thyroid and Salivary Imaging		
Venography/Thrombus Imaging <i>(other)</i>			
F-18(etc.)	P.E.T. Imaging		
RADIOPHARMACEUTICAL PREPARATION			
Mo/Tc	Generator Elution and Testing		
Tc-99m	Reagent Kit Preparation and Testing		
	<i>(other)</i>		

Proposed Physician User: _____

Column A Radionuclide	Column B Condition Treated	Column C Number of Cases Involving Personal*	Column D Comments
I-131 (NaI)	Hyperthyroidism/Graves/Multinodular Goiters		
	Thyroid Cancer/Metastasis		
I-131 (MoAb)	Non-Hodgkin's Lymphoma		
Y-90 (MoAb)	Non-Hodgkin's Lymphoma		
P-32(soluble)	Polycythemia etc.		
P-32(colloidal)	Intracavitary malignant effusions etc.		
Sr-89	Palliative Bone Pain from Bone Metastasis		
Sm-153	Palliative Bone Pain from Bone Metastasis		
	<i>(other e.g., Investigational Drugs)</i>		
Sr-90	Superficial eye conditions		
I-125	Eye plaques		
I-125	Interstitial Cancer		
Pd-103	Interstitial Cancer		
Au-198	Interstitial Cancer		
Cs-137	Intracavitary Cancer		
Ir-192	Interstitial Cancer		
Co-60	External Beam Therapy		
Ir-192	High Dose Rate After-loader Therapy		System
Sr-90, P-32, Ir-192	Intravascular Brachytherapy		System
	<i>(other)</i>		

*KEY TO COLUMN "C"

- Supervise examination of patients to determine the suitability for radionuclide diagnosis and/or treatment and recommendation for prescribed dosage.
- Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data.
- Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.

Reference 25 TAC §289.256

A. Total Hours of Work and Clinical Training Combined:

Experience: _____ Hours Obtained at: _____

Diagnostic physician user training must have included the following:

- Ordering, receiving, unpackaging, surveying
- Calibrating dose calibrators and diagnostic instruments
- Calibrating and preparing patient doses
- Using administrative controls to prevent misadministrations
- Contain spills and perform decontamination
- Elute Mo/Tc generators, test eluate and prepare kits
- Review patient history; select measure and administer dosages; collaborative reporting; follow-up
- Physics and instrumentation; protection; mathematics; pharmaceutical chemistry; radiation biology

Total Hours of Didactic (*Classroom and Laboratory*):

Training: _____ Hours Attended at: _____

[OR]

B. Accepted Board Specialty: _____ Date Issued: _____

I CERTIFY THAT THE ABOVE NAMED PHYSICIAN SUCCESSFULLY COMPLETED THE SPECIFIED TRAINING AS PRESCRIBED IN TITLE 25 TEXAS ADMINISTRATIVE CODE and HAS ACHIEVED A LEVEL OF COMPETENCE TO FUNCTION INDEPENDENTLY AS AN AUTHORIZED USER. I AM AN AUTHORIZED USER FOR THE TYPE(S) OF RADIOACTIVE MATERIAL USE(S) REQUESTED BY THIS PHYSICIAN.

_____ at _____		
Name of Physician (Preceptor)	Institution	Signature
Institutional RAM License No.	Address	Telephone Number
NRC State Agreement State	<input type="checkbox"/> <input type="checkbox"/>	
Expiration Date: _____	City/State/Zip	Date