



DEPARTMENT OF STATE HEALTH SERVICES
Radiation Safety Licensing Branch
Mammography Certification
Amendment Application

Complete this application and submit to either address below. (Use supplemental sheets as necessary) Retain a copy of the application for your files.

U.S. Postal service address:

Department of State Health Services
 Radiation Safety Licensing Branch
 Mammography Certification Program
 P.O. Box 149347, Mail Code (MC) 2835
 Austin, Texas 78714-9347

Overnight/express service address

Department of State Health Services
 Radiation Safety Licensing Branch
 Mammography Certification Program
 1100 West 49th Street
 Austin, Texas 78756

Mammography Certification Program (512) 834-6688 - Fax (512) 834-6716

Section 1: General Information

Mammography Certification Number: _____ MQSA Facility Identification Number _____

Legal Name of Facility: _____
 (Name should match that on Business Information Form RC 226-1)

Doing Business As (if applicable): _____
 (Name should match that on Business Information Form RC 226-1)

County _____

Mailing Address: (Street/City/State/Zip) _____ Machine Use Location Address: (Street/City/State/Zip) _____
(If multiple use locations, use additional sheets)

Facility Phone Number: _____ Fax No.: _____

Lead Interpreting Physician: _____

Radiation Safety Officer (RSO): _____
Attach qualifications as required in 25 TAC §289.226(t)(1) **only** if changing Radiation Safety Officer

Telephone No.: _____ E-mail address: _____

Contact Person & Title: _____

Telephone No.: _____ E-mail address: _____

Check if applicable: New equipment being added. Equipment being deleted. (Include transfer/disposal form)
 New total number of machines on this certification: _____

Number of Mammography units: _____ Number of Stereotactic Biopsy units (stand-alone): _____

Number of Stereotactic Biopsy Attachments Used with a Mammography Unit _____

Section 2: Personnel

- List all mammography personnel currently affiliated with the facility.
- Make copies of this form as needed or attach list of personnel.

Interpreting Physician(s):

Radiologic Technologist(s)

Medical Physicist(s):

Section 3: Equipment Information

Complete this section for each mammography x-ray unit.

Include a copy of a current medical physicist's survey report for each machine. (Note, if there are any failures and/or deficiencies on the report, attach a list of corrective actions and include copies of service/work invoices with the description of corrective actions.)

Machine Use Address: _____

Site Number _____ Number of machines located at this site (address): _____

1. Control Panel Manufacturer: _____ Control Panel Model Name & Number: _____ Control Panel Serial Number _____
2. Type of Imaging System: Screen/Film Digital Digital Fuji CR
3. Is this unit used for a mobile operation? Yes No
4. Indicate the service for which this unit is used. Mammography Breast Biopsy*

*If using a Stereotactic Biopsy Attachment with a Mammography Unit and not a stand-alone biopsy unit, include the following information on the biopsy attachment:

Manufacturer Model Number Serial Number

Section 4: Accreditation Information

Accreditation Body: Texas American College of Radiology (ACR)

Section 5: Mobile Service Operation

Authorization from the Department is required prior to initiating mobile service operations.

For mobile mammography service operations, complete this section **only** if requesting authorization and authorization has not been received previously **or** if information submitted previously has changed. [25 TAC§289.226(g)]

Main location where machine and records will be maintained for inspection. This must be a street address.

Street _____

City _____

State _____

Zip _____

Attach a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

Submit a current copy of the mobile service operations Operating and Safety Procedures regarding radiological practices for protection of patients, operators, employees, and the general public.

Section 6-Self-referral Authorization

Self-referral is site based. All sites must have authorization from the Department prior to performing self-referred mammograms.

Complete this section **only** if requesting authorization to conduct self-referral mammography, if adding self-referral authorization to additional sites, **or** if procedures have changed. [25 TAC§289.230 (cc)]

Number of views for a typical mammogram—_____

Type of views for a typical mammogram_____

ATTACH the following:

- o the age range of the population to be examined and the frequency of the exam following established, nationally recognized criteria of the American Cancer Society, American College of Radiology, the National Council on Radiation Protection and Measurements;
- o method of recommending to patients who do not have a physician, means of selecting a physician;
- o written procedures for advising individuals and their private physicians of the results of the self-referred exam and any further medical needs indicated. Include a method of follow-up to confirm that patients with positive findings, as well as practitioners, have received proper notification;
- o description of the methods used to educate patients in self-examination techniques, and on the necessity for follow-up by a physician; and
- o film retention policy if different from the policy in Section 7.

Procedures enclosed

No change to procedures previously submitted

Section 7: Medical Records Retention Policy

Submit procedures for disposition/retention of medical records, including films, in the event of termination, failure to renew, or bankruptcy **only** if not submitted previously **or** if there has been a change in procedures.

Policy enclosed

No change to policy previously submitted

Section 8: Signatures

I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of person completing the application Date Signature

Typed or printed name and title Date Signature
This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.

I assume the responsibilities of **lead interpreting physician** as described in 25 TAC §289.230(k)(1)(A) for the facilities listed in this application.

Typed or printed name of lead interpreting physician Date Signature

I assume the responsibilities of **RSO** as described in 25 TAC §289.226(t)(2) for the facilities listed in this application. I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of RSO Date Signature

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

