



**RC Form 256-2b AUTHORIZED MEDICAL PHYSICIST TRAINING AND  
EXPERIENCE AND PRECEPTOR ATTESTATION**  
*Post Graduate Degree and Experience*

Name of Proposed Authorized Medical Physicist	License No.
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Requested Authorization(s) *Check all that apply*

§289.256(rr) Ophthalmic use of Strontium-90

§289.256(ddd) Remote Afterloader Unit(s)

§289.256(ddd) Teletherapy Unit(s)

§289.256(ddd) Gamma Stereotactic Radiosurgery Unit(s)

**Part I – Training and Experience**

Training and experience, including board certification, must have been obtained within the preceding 7 years or the individual must have obtained related continuing education and experience since the initial training and experience was completed. Provide dates, duration, and a description of continuing education and experience related to the uses checked under "Requested Authorizations."

- A 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	

- Completed one year of full time training in medical physics and an additional year of full-time work experience under the supervision of an authorized medical physicist at a clinical radiation facility that provides high-energy, external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts), and brachytherapy services, including the following:

Description of Training/Experience	Location of Training/License Number of Facility/Devices Used	Dates of Training	Dates of Work Experience
Medical physics			
Performing sealed source leak tests and inventories			

Description of Training/Experience ( <i>continued</i> )	Location of Training/License Number of Facility/Devices Used	Dates of Training	Dates of Work Experience
Performing decay corrections			
Performing full calibration and periodic spot checks of external beam treatment units			
Performing full calibration and periodic spot checks of stereotactic radiosurgery units			
Performing full calibration and periodic spot checks of remote afterloading units			
Conducting radiation surveys around external beam treatment units, stereotactic radiosurgery units, remote afterloading units			
Supervising Individual	License No. authorizing supervising individual		
<input type="checkbox"/> Describe training, including provider and dates of training, for each type of use sought. Training may be provided by the vendor or by a supervising medical physicist.			
Description of Training	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 applicable)	License No. authorizing supervising individual		

**Part I – Training and Experience** (continued)

If applicable:

Authorization Sought	Device	Training Provided By	Dates of Training
Ophthalmic use of Strontium-90			

**Part II – Preceptor Attestation**

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  
*Name of Proposed Authorized Medical Physicist*

the requirements in §289.256(j)(2)(A) and (2)(B) and (3) and has achieved a level of competency sufficient to function independently as an authorized medical physicist for the following medical uses:

- §289.256(rr) Ophthalmic use of Strontium-90
- §289.256(ddd) Remote Afterloader Unit(s)
- §289.256(ddd) Teletherapy Unit(s)
- §289.256(ddd) Gamma Stereotactic Radiosurgery Unit(s)

I am an Authorized Medical Physicist for the following uses:

- §289.256(rr) Ophthalmic use of Strontium-90
- §289.256(ddd) Remote Afterloader Unit(s)
- §289.256(ddd) Teletherapy Unit(s)
- §289.256(ddd) Gamma Stereotactic Radiosurgery Unit(s)

Preceptor Name (Print)	Signature	Phone Number
License Number/Facility Name	Date	

**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.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004.)