



**APPLICATION FOR RECOGNITION OF A
CLINICAL PRACTICE SETTING IN MEDICAL DOSIMETRY
FORM 104MD**

Sponsoring Institution: _____ **Program #** _____

I. CLINICAL PRACTICE SETTING FOR WHICH JRCERT RECOGNITION IS SOUGHT:

Name

Address

City

State

Zip Code

CPS # _____ (To be assigned by JRCERT)

This application must be completed for **each** clinical practice setting.

- Consistent with **JRCERT Policy 11.400, Procedure 11.404D**, the JRCERT considers a clinical practice setting as all radiologic facilities under a single radiologic administration within the campus. A campus is defined as the buildings and grounds of a school, college, university, or hospital that are geographically contiguous and does NOT include any geographically dispersed campus of a sponsor. Separate recognition is required for each facility not meeting this definition.
- **Enclose:**
 - a. An affiliation agreement with Affiliation Agreement Criteria sheet attached (see page 6).
 - b. **Form 102MD** for each designated clinical preceptor and all required attachments identified on the form.
 - c. Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for the clinical practice setting for which recognition is sought. For non-hospital clinical practice settings that are not accredited, documentation of compliance with state and/or federal radiation safety regulations may be used as equivalent.
- An application for recognition is not guaranteed. Recognition may be denied, or the capacity authorized may be less than that requested by the program.
- **Fee:** please see the current Fee Schedule at www.jrcert.org.

I. INSTITUTIONAL/PROGRAM OFFICIALS:

The signatures of sponsoring institution and program officials constitute a request for JRCERT recognition of the facility as a clinical practice setting for the requesting program.

Chief Executive Officer of Clinical Practice Setting:

Name (Print)	Degree/Credentials	Title
Signature		

Clinical Preceptor(s):

Complete JRCERT **Form 102MD**, and provide a current **curriculum vitae, and documentation of current MDCB registration or unrestricted state license** for each individual listed. *(Add additional page if necessary.)*

- A minimum of one clinical preceptor must be identified for each clinical practice setting.
- One full-time equivalent clinical preceptor must be identified for every five (5) students involved in the competency achievement process.

Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
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Name	Degree/Credentials
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Name	Degree/Credentials
Name	Degree/Credentials

Provide documentation of baccalaureate or higher degrees. *(Although not required for clinical preceptors, the JRCERT database will reflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical preceptor, it will be assumed that the program does not wish to have the degree noted.)*

III. CLINICAL CAPACITY - the JRCERT will determine the clinical capacity for this facility based on documented availability of appropriate procedures and qualified practitioners to assure student attainment of program learning outcomes.

List the qualified practitioners (MDCB certification or equivalent) that are assigned to ***a typical weekday*** (Monday-Friday) who perform medical dosimetry procedures. **The ratio of students to staff prior to student competency achievement in a given examination or procedure shall not exceed 2:1.**

Shift Hours

Name of Medical Dosimetrist $\frac{\text{.}}{\text{.}} - \frac{\text{.}}{\text{.}}$
begin end

Name of Medical Dosimetrist $\frac{\text{.}}{\text{.}} - \frac{\text{.}}{\text{.}}$
begin end

Name of Medical Dosimetrist $\frac{\text{.}}{\text{.}} - \frac{\text{.}}{\text{.}}$
begin end

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begin end

Name of Medical Dosimetrist $\frac{\text{.}}{\text{.}} - \frac{\text{.}}{\text{.}}$
begin end

IV. SITE UTILIZATION

A. Program seeking recognition for use of this facility. In the chart below, indicate the requested number of students to be assigned from each cohort group and the beginning and ending time of each day’s rotation. If all students are assigned to the same start and end times, indicate this in the “Shift A” section (skip “Shift B” section). If students are assigned to two start/end times, please indicate the additional times in the “Shift B” section.

	Monday	Tuesday	Wednesday	Thursday	Friday
1 st Year - “Shift A” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
1 st Year - “Shift B” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
2 nd Year - “Shift A” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
2 nd Year - “Shift B” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year - Fall Spring Summer Other _____
Please indicate

2nd Year - Fall Spring Summer Other _____
Please indicate

Based on the recognition of this facility, the program’s total capacity will:

remain the same **OR** increase by _____ students

SHARED SITE INFORMATION

Complete this section ONLY if the site is currently recognized for student placement by a JRCERT accredited program. If not, move to page 7.

NOTE: If the total number of students identified below is less than the number currently on the JRCERT database for this facility, the clinical capacity will be decreased to the number indicated.

B. Name of program currently recognized for use of this facility - _____
Name of Program

(If site is currently used by more than one program, information must be provided by each.)

To complete, see directions in Section “A” above.

	Monday	Tuesday	Wednesday	Thursday	Friday
1 st Year - “Shift A” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
1 st Year - “Shift B” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
2 nd Year - “Shift A” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end
2 nd Year - “Shift B” # of Students	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end	__ : __ - __ : __ begin end

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year - Fall Spring Summer Other _____
Please indicate

2nd Year - Fall Spring Summer Other _____
Please indicate

Programs should use this section to document comments.

RADIATION ONCOLOGY DEPARTMENTAL ADMINISTRATOR

I agree that the information provided on this form is correct.

Name (Print)

Title

Signature

PROGRAM DIRECTOR/EDUCATIONAL COORDINATOR- PROGRAM SEEKING SITE RECOGNITION

I agree that the information provided on this form is correct and that if recognition of this site is granted, the program will abide by the usage of the site as proposed.

Name (Print)

Signature

PROGRAM DIRECTOR /EDUCATIONAL COORDINATOR - PROGRAM HOLDING CURRENT SITE RECOGNITION.

To be completed ONLY if site is to be shared.

Pages 13 & 14 must be completed by ALL programs with current site recognition (including those sites identified as inactive).

I agree that the information provided on this form is correct and that the program will abide by the usage of the site described.

Name (Print)

Program #:

Signature

V. AFFILIATION AGREEMENT CRITERIA:

Attach a copy of this page to the front of each signed affiliation agreement submitted.

Sponsoring Institution: _____ **Program #** _____

Clinical Practice Setting Name: _____

The affiliation agreement must identify the following three (3) criteria as outlined below. Please identify where they are located in the document by highlighting, circling, or otherwise indicating the verbiage AND identifying the page and paragraph number for each.

RESPONSIBILITY FOR STUDENT SUPERVISION:
Page and Paragraph Number _____

ADEQUATE NOTICE OF TERMINATION OF THE AGREEMENT:
Page and Paragraph Number _____

The JRCERT considers three months notice of termination or assurance that students currently enrolled will be provided the opportunity to complete the clinical component of the program as being appropriate.

RESPONSIBILITY FOR LIABILITY:
Page and Paragraph Number _____

NOTE: An affiliation agreement is not required for clinical practice settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.