



Joint Review Committee on Education in Radiologic Technology
20 N. Wacker Drive, Suite 2850, Chicago, IL 60606-3182 • Tel: (312) 704-5300 • Fax: (312) 704-5304

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

Name of Program _____ **Program #** _____

- This Application must be completed by programs requesting recognition of a **NEW** Clinical Practice Setting.
- The signatures of sponsoring institution/program officials constitute a request for JRCERT recognition of the facility as a clinical practice setting for the requesting program.
- Per JRCERT Policy 11.400, Procedure 11.404Ciii, if the clinical practice setting is currently recognized for another accredited educational program(s) in this discipline, documentation of a meeting that includes representatives of the program(s) and the clinical practice setting must be submitted with the application. The meeting minutes must document discussion of student capacity, supervision and scheduling, and **must be signed** by all participants.
- **Enclose:**
 - a. Affiliation agreement, if applicable.
 - b. **Form 102MD** for each designated clinical preceptor.
 - 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 or federal radiation safety regulations may be used as equivalent.
 - d. \$250 application fee (not required for applications submitted with initial program application/self-study report).

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

Name

Address

City State Zip Code

II. ACCREDITATION OF THE CLINICAL PRACTICE SETTING FOR WHICH RECOGNITION IS SOUGHT: *(Attach verifying documentation.)*

Agency _____
Status _____
Date Awarded _____
Term _____

III. STUDENT CAPACITY

Determined by the program to support student attainment of program learning outcomes based on documented availability of qualified faculty, appropriate equipment and the volume and variety of examinations and procedures available in the clinical practice setting.

- One clinical preceptor for each clinical practice setting.
- One full-time equivalent clinical preceptor for every 5 students involved in the competency achievement process must be documented.
- The ratio of students to staff prior to student competency achievement in a given examination or procedure shall not exceed 1:1.

Maximum number of students program may assign to this site at any one time: _____

The clinical total capacity for a clinical site is the maximum number of students the program applying for recognition may assign to this facility at any one time.

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

remain the same OR increase by _____ students

IV. AFFILIATION AGREEMENT Enclosed

A copy of the signed affiliation agreement between the sponsor and this clinical practice setting must be attached.

The affiliation agreement must address responsibility for student **supervision**, student **professional liability**, and **termination** of the agreement. JRCERT Policy 11.400, Procedure 11.404Civ requires that an affiliation agreement contains an appropriate termination clause. The JRCERT considers three (3) 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.

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

V. INSTITUTIONAL/PROGRAM OFFICIALS:

Chief Executive Officer of Clinical Practice Setting:

Name (Print)	Degree/Credentials	Title
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Signature

Mailing Address

City	State	Zip Code
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Area Code and Business Phone Number

Radiology Departmental Administrator of Clinical Practice Setting:

Name (Print)	Degree/Credentials	Title
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Signature

Mailing Address

City	State	Zip Code
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Area Code and Business Phone Number

Program Director:

Name (Print)	Degree/Credentials
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Signature

Mailing Address

City	State	Zip Code
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Area Code and Business Phone Number	Fax Number	E-mail Address
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Clinical Preceptor(s):

Complete JRCERT **Form 102MD** for each individual listed. *(Add additional page if necessary.)*

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

Name Degree/Credentials

Signature

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.)