

**JRCERT New Clinical Setting Recognition Information Needed**

Affiliation Agreement in pdf format  
Accreditation documentation in pdf format

Clinical Setting Name

Address

City, State Zipcode

Number of Imaging Rooms

Number of Mobile and/or C-ARMS

Number of Qualified Practitioners

Clinic Capacity Requested

Shared Clinical Setting (Yes/No)

**Radiology Department Administrator:**

Prefix (Mr./Dr./Ms., etc.)

Name

Title

E-mail Address

Degree/Credentials

**Clinical Instructor:**

Prefix (Mr./Dr./Ms., etc.)

Name

Title

E-mail Address

Degree/Credentials

Copy of ARRT in pdf format

CV in pdf format