Joint Review Committee on Education in Radiologic Technology
20 N. Wacker Drive, Suite 2850
Chicago, IL 60606-3182
312.704.5300
www.jrcert.org

CLINICAL CAPACITY CHANGE – RADIOGRAPHY
FORM 1010R

I. General Information

Program Name	
JRCERT Program Number	
Clinical setting for which capacity change is sought	
Clinical Setting Address	

II. Clinical Capacity

The JRCERT will determine the clinical total capacity for this facility based upon the **lower available resource** identified as follows:

> Please identify the total number of imaging units (physical resources) located on the campus of this facility. This would NOT include mammography, CT, MR, Ultrasound, Nuclear Medicine, Interventional, Cardiovascular, Bone Densitometry or Therapy equipment. Note: A campus is defined as the buildings and grounds of a school, college, university, or hospital and does NOT include any geographically dispersed campus. Separate recognition is required for each facility not meeting this definition.
>
> Additionally, please identify the total number of qualified practitioners/radiographers (human resources) scheduled to be present on a typical day during the time of day that students will be on site.

Total number of radiographic plus R&F rooms	
Total number of mobile and c-arm units	
Total number of qualified practitioners/radiographers typically scheduled during the time of day students will be on site	
New requested clinical capacity (number of students program will assign to the facility at any one time)	

III. Program Total Capacity

Based on the requested change in clinical capacity of this facility, the program would like the program total capacity

to ☐ Remain the same **OR** ☐ Increase by _____ students **OR** ☐ Decrease by _____ students

IV. Signature

The following signature constitutes a request for a change in clinical capacity of this facility and is accurate to the best of my knowledge.

Program Director Signature	I agree that typing my name qualifies as my signature.