MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF DIAGNOSTIC SERVICES --- RADIATION CONTROL PROGRAM

REGISTRATION AND RECOGNITION AS A QUALIFIED EXPERT IN RADIATION SAFETY AND/OR MEDICAL PHYSICS

SECTION I: GENERAL INFORMATION

FIRST NAME:	LAST NAME:	SUFFIX (Ph.D., MS, BS, Etc.)

MAILING ADDRESS:

CITY	STATE	ZIP	COUNTY

PRIMARY PHONE NUMBER:	ALTERNATE NUMBER:	EMAIL ADDRESS:
( )	( )	

COMPANY NAME OR PRIMARY PLACE OF EMPLOYMENT:

COMPANY ADDRESS: (STREET, CITY, STATE, ZIP)

TITLE/POSITION

SECTION II: CATEGORIES OF RECOGNITION — Check applicable Pathway

☐ PATH ONE: NATIONALLY-RECOGNIZED CERTIFYING BODY	☐ PATH THREE: BACHELORS DEGREE PLUS TRAINING AND EXPERIENCE
☐ PATH TWO: MASTERS/PH.D. DEGREE PLUS TRAINING AND EXPERIENCE	☐ PATH FOUR: ALTERNATE STANDARD/RECOGNITION BY PETITION

PATH ONE: NATIONALLY-RECOGNIZED CERTIFYING BODY

BOARD CERTIFICATION

- ☐ AMERICAN BOARD OF RADIOLOGY (ABR)
- ☐ AMERICAN BOARD OF MEDICAL PHYSICS (ABMP)
- ☐ CANADIAN COLLEGE OF MEDICAL PHYSICS (CCMP)
- ☐ AMERICAN BOARD OF HEALTH PHYSICS (ABHP)

AREA OF CERTIFICATION

- ☐ RADIOLOGICAL PHYSICS
- ☐ DIAGNOSTIC RADIOLOGICAL PHYSICS
- ☐ THERAPEUTIC RADIOLOGICAL PHYSICS
- ☐ ROENTGEN RAY & GAMMA RAY PHYSICS
- ☐ X-RAY & RADIUM PHYSICS
- ☐ OTHER (SPECIFY) _____

ATTACH 3RD PARTY DOCUMENTATION (COPY OF BOARD CERTIFICATION)

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PATH TWO: MASTERS/PH.D DEGREE PLUS TRAINING AND EXPERIENCE

☐ PH.D. COLLEGE/UNIVERSITY _____

☐ MS DEGREE DATE DEGREE RECEIVED _____

AND

Minimum of one (1) year full time training and one (1) year full time of professional/clinical work experience under supervision acceptable to the Department.

TRAINING

DATES:_____ SUPERVISED BY (INCLUDE CONTACT INFO)_____

_____

FACILITY/COMPANY AND LOCATION_____

_____

PROFESSIONAL/CLINICAL EXPERIENCE UNDER SUPERVISION

DATES:_____ SUPERVISED BY (INCLUDE CONTACT INFO)_____

_____

FACILITY/COMPANY AND LOCATION_____

_____

AND

RECENT RADIATION SURVEY OR CONSULTATION EXPERIENCE

Evidence of a minimum of two (2) surveys within the last two (2) years.

SURVEY/CONSULTATION FACILITY 1	SURVEY/CONSULTATION FACILITY 2
DATE:_____	DATE:_____
FACILITY/COMPANY LOCATION_____	FACILITY/COMPANY LOCATION_____
SERVICE TYPE PROVIDED_____	SERVICE TYPE PROVIDED_____
_____	_____

AND

ATTACH DOCUMENTATION/EVIDENCE OF THE ABOVE

- Copy of Diploma and/or Transcript
- Evidence of Training and Clinical Experience such as:
  →A detailed description of your radiation safety experience including: Facilities; Dates; Supervisors; QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used
  →Supervisor(s) statement describing the nature of the experience and the supervision given. The statement should demonstrate that the supervisor meets the common qualifications of recognition as a Qualified Expert.
- Evidence of Radiation Surveys (Copies of Reports or Cover Letters, etc)

REGISTRATION AND RECOGNITION AS A QUALIFIED EXPERT IN RADIATION SAFETY AND/OR MEDICAL PHYSICS

PATH THREE: BACHELORS DEGREE PLUS TRAINING AND EXPERIENCE

☐ B.S. COLLEGE/UNIVERSITY _____ DATE DEGREE RECEIVED _____

MAJOR/EMPHASIS (30 CREDIT HOURS IN NATURAL SCIENCE OR MATH):_____

AND

Four (4) years applied radiation protection experience, of which at least one (1) year includes applicable survey experience under supervision acceptable to the Department.

TRAINING

DATES:_____ SUPERVISED BY (INCLUDE CONTACT INFO)_____

_____

FACILITY/COMPANY LOCATIONS_____

_____

EXPERIENCE (AT LEAST ONE YEAR UNDER SUPERVISION)

DATES:_____ SUPERVISED BY (INCLUDE CONTACT INFO)_____

_____

FACILITY/COMPANY AND LOCATION(S)_____

DESCRIBE ADDITIONAL EXPERIENCE AS APPLICABLE SEPARATELY_____

_____

_____

_____

AND

RECENT RADIATION SURVEY OR CONSULTATION EXPERIENCE

Evidence of a minimum of two (2) surveys within the last two (2) years.

SURVEY/CONSULTATION FACILITY 1	SURVEY/CONSULTATION FACILITY 2
DATE:_____	DATE:_____
FACILITY/COMPANY LOCATION_____	FACILITY/COMPANY LOCATION_____
SERVICE TYPE PROVIDED_____	SERVICE TYPE PROVIDED_____
_____	_____

AND

ATTACH DOCUMENTATION/EVIDENCE OF THE ABOVE

- Copy of Diploma and/or Transcript
- Evidence of Training and Clinical Experience such as:
  →A detailed description of your radiation safety experience including: Facilities; Dates; Supervisors; QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used
  →Supervisor(s) statement describing the nature of the experience and the supervision given. The statement should demonstrate that the supervisor meets the common qualifications of recognition as a Qualified Expert.
- Evidence of Radiation Surveys (Copies of Reports or Cover Letters, etc)

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PATH FOUR: ALTERNATIVE STANDARD/RECOGNIZED BY PETITION

☐ I do not meet the qualifications specified in Pathways 1, 2 or 3 above. However, I believe I am qualified to perform or direct competent and dependable radiation safety surveys and/or consultations in the category (or categories) for which I am applying, as I have relevant educational, professional, clinical or technical experience or equivalent certification from other certifying bodies not named in Pathway 1.

Document(s) Submitted to support Petition for Qualified Status	CHECK IF ENCLOSED
--Curriculum Vitae	
--Copy of Undergraduate and Graduate Degree	
--College Transcript (If field of study is not clear on degree)	
--Applicable Continuing Education (Post-graduate) Information	
--Detailed description of your radiation safety experience including: Facilities; Dates; Supervisors; QC/Rad Safety Tests and Responsibilities; Types of Radiation Producing Equipment Used	
--Supervisor(s) statement describing the nature of the experience and the supervision given. The statement should demonstrate that the supervisor meets the common qualifications of recognition as a Qualified Expert.	
--Copy of Board Certification, name and address of Board, and Certifying Board's prospectus describing certification criteria at the time of your initial certification.	
--If documentation is other than above, describe separately at length, in detail. Note that the **burden of evidence is on the petitioner**.	

:

ONGOING/CURRENT EXPERIENCE PROVIDING RADIATION SAFETY SURVEYS/ CONSULTATION

TOTAL SURVEYS/CONSULTATION PERFORMED IN THE LAST TWO YEARS:_____

ATTACH A LIST (INCLUDING FACILITY CONTACT INFORMATION) OR COPIES OF REPORTS, CONSULTATIONS, ETC

SECTION III: AREAS OF EXPERTISE

Areas of survey specialization for requested recognition of Qualified Expert status.

My training and experience as described above has enabled me to perform or direct competent and dependable surveys and/or radiation consultation in the following specialized areas; and I am able to provide specific evidence of both training and experience in the areas indicated upon request.

☐ 1. HEALTH PHYSICS CONSULTATION
☐ 2. DIAGNOSTIC RADIOGRAPHIC (MEDICAL/CHIROPRACTIC/PODIATRIC)
☐ 3. MAMMOGRAPHY (MUST CONFORM TO FEDERAL MQSA STANDARDS)
☐ 4. FLUOROSCOPY/INTERVENTIONAL RADIOLOGY
☐ 5. NON-MEDICAL/INDUSTRIAL/ACADEMIC/RESEARCH
☐ 6. THERAPY/LINEAR ACCELERATOR
☐ 7. SHIELDING DESIGN
☐ 8. C.T.
☐ 9. BONE DENSITY/DEXA
☐ 10. DENTAL (NON CBCT)
☐ 11. VETERINARY RADIOLOGY
☐ 12. OTHER (DESCRIBE BELOW):

_____

_____

_____

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SECTION IV: AVAILABILITY FOR CONSULTATION

The listing of available Qualified Experts and their areas of expertise will be provided to registered radiation facilities. Please indicate your availability for consultation.

☐ **Available for radiation safety consultation or surveys with Missouri registrants for a fee.**

☐ **NOT available for consulting outside my primary work place**.

SECTION V: ACKNOWLEDGEMENT OF ADDITIONAL RECOGNITION REQUIREMENTS

☐ I understand that recognition as a Qualified Expert may be denied or revoked or limited due to problems regarding the reliability of the consultation/survey(s) resulting from:

---Falsification of data/information, either on the application for recognition or survey/consultation documents;

---Negligence in the performance of radiation consultation/surveys such that significant error results;

---Utilization of methods or procedures that do not conform (when applicable) to existing generally-accepted professional standards (such as those described in documents published by AAPM, ACR, or other recognized professional organizations)

---Lack of adequate oversight/direction of individual(s) performing tests or gathering data under review/signature of the Qualified Expert;

---Failure to provide adequate survey documentation to the MRCP upon request;

---Failure to provide adequate documentation of qualifications to the MRCP upon request, including evidence of initial or (upon re-registration every two years) continuing professional education and experience;

---Other problems that significantly impact the reliability of the consultation services provided by the Qualified Expert

SECTION VI: SIGNATURE

Signature by the applicant below certifies that:

I certify that the information provided on this application is true and accurate, and I give my permission to Department officials to verify information as needed.

SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY

INITIAL REVIEW BY:	RECOMMENDATION	DATE REVIEWED:
APPROVED BY:	TITLE:	DATE APPROVED:
MISSOURI QUALIFIED EXPERT IDENTIFICATION CODE ASSIGNED:		

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