FORM DHHS/RHS-1

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## APPLICATION FOR RADIOACTIVE MATERIAL LICENSE

INSTRUCTIONS: Complete items 1 through 15 of this application. Use supplemental sheets where necessary. Item 15 shall be completed on all applications. Mail the original and one copy of the application package to: ~~NH DHHS~~ Radiological Health Section, Division of Public Health Services, ~~Health and Welfare Building,~~ Department of Health and Human Services, 29 Hazen Drive, Concord, New Hampshire 03301~~-6503~~. Upon approval of an application, the applicant shall receive a Radioactive Material License issued pursuant to statutory and implementing regulatory authority and subject to all applicable rules and orders of all appropriate regulatory agencies now or hereafter in effect and to any conditions specified in the license.

| | |
|---|---|
| 1a. NAME AND MAILING ADDRESS OF APPLICANT (institution, firm, clinic, physician, etc.)<br><br>Tel. # ( ) Fax # ( ) | 1b. STREET ADDRESS(ES) AT WHICH RADIOACTIVE MATERIAL WILL BE USED (if different from 1a) |
| 2. PERSON TO CONTACT REGARDING THIS APPLICATION<br><br>Tel. # ( ) _____-_____<br><br>Email: _____ | 3. THIS APPLICATION IS FOR (check appropriate item):<br><br>a. ☐ New license<br><br>b. ☐ Renewal of license no. _____ |
| 4. RADIATION SAFETY OFFICER (Name of person designated as radiation safety officer. Submit a completed form DHHS/RHS-1 ~~If other than individual user, complete~~ Supplement A to document ~~, Resumé stating~~ training and experience ~~optional.)~~ | 5. INDIVIDUAL USERS (Name of individual(s) to be authorized to ~~who will~~ use or directly supervise use of radioactive material. Submit a ~~C~~completed Form DHHS/RHS-1 Supplement A for each individual.) |

6. RADIOACTIVE MATERIAL

| ELEMENT AND MASS NUMBER | CHEMICAL AND/OR PHYSICAL FORM | NAME OF MANUFACTURER AND MODEL NUMBER (If Sealed Source) | MAXIMUM ACTIVITY (~~NUMBER OF~~ MILLICURIES) ~~AND/OR SEALED SOURCES AND~~ TO BE POSSESSED AT ONE TIME: MAXIMUM ACTIVITY PER SEALED SOURCE AND NUMBER OF SEALED SOURCES ~~WHICH WILL BE POSSESSED AT ONE TIME~~ |
|---|---|---|---|
| A. | A. | A. | A. |
| B. | B. | B. | B. |
| C. | C. | C. | C. |
| D. | D. | D. | D. |

DESCRIBE USE OF RADIOACTIVE MATERIAL

| |
|---|
| A. |
| B. |
| C. |
| D. |

7. STORAGE OF SEALED SOURCES

| CONTAINER AND/OR DEVICE IN WHICH EACH SEALED SOURCE WILL BE STORED OR USED | NAME OF MANUFACTURER | MODEL NUMBER |
|---|---|---|
| A. | A. | A. |
| B. | B. | B. |
| C. | C. | C. |
| D. | D. | D. |

8. RADIATION DETECTION INSTRUMENTS

| TYPE OF INSTRUMENT | MANUFACTURER'S NAME | MODEL NUMBER | NUMBER AVAILABLE | RADIATION DETECTED (alpha, beta, gamma, neutron) | SENSITIVITY RANGE (mR/hr or counts/min) |
|---|---|---|---|---|---|
| A. | | | | | |
| B. | | | | | |
| C. | | | | | |
| D. | | | | | |

9. CALIBRATION OF INSTRUMENTS LISTED IN ITEM 8

☐ a. CALIBRATED BY SERVICE COMPANY
Name, Address and Frequency

☐ b. CALIBRATED BY APPLICANT

Attach separate sheet describing method, frequency and standards used for calibrating instruments.

10. PERSONNEL MONITORING DEVICES

| TYPE (Check and/or complete as appropriate) | SUPPLIER (Service Company) | EXCHANGE FREQUENCY |
|---|---|---|
| ☐ (1) ~~Film Badge~~ Whole Body (Film / TLD / OSL circle type) | | |
| ☐ (2) Extremity ~~Whole Body~~ Dosimeter ( Film / TLD~~/OSL~~ circle type) | | |
| ☐ (3) Other (Specify): | | |

11. FACILITIES AND EQUIPMENT
Check where appropriate and attach annotated sketch(es) and description(s).

☐ a. LABORATORY FACILITIES, PLANT FACILITIES, FUME HOODS (include filtration, if any), ETC.

☐ b. STORAGE FACILITIES, SECURITY MEASURES, ~~CONTAINERS,~~ SPECIAL SHIELDING (for fixed and/or temporary locations), ETC.

☐ c. REMOTE HANDLING TOOLS OR EQUIPMENT, ETC.

☐ d. RESPIRATORY PROTECTIVE EQUIPMENT, ETC.

## 12. WASTE DISPOSAL

| a. NAME OF COMMERCIAL WASTE DISPOSAL SERVICE EMPLOYED | If commercial waste disposal service is not employed, submit a detailed description of methods which will be used for disposing of radioactive wastes and estimates of the type and amount of activity involved. If the application is for sealed sources and devices and they will be returned to the manufacturer, so state. |
|---|---|

## 13. RADIATION PROTECTION PROGRAM

Describe the radiation protection program as appropriate for the material to be used including the duties and responsibilities of the Radiation Safety Officer, control measures, bioassay procedures (if needed), day-to-day general safety instruction to be followed, etc.

–If the application is for sealed sources also submit leak testing procedures, or if leak testing will be performed using a leak test kit, specify manufacturer and model number of the leak test kit.

## 14. SPECIFIC LICENSE FEE (Refer to Part He-P 4070, New Hampshire Rules for the Control of Radiation.)

Category: _____ Amount Enclosed: $_____

## 15. CERTIFICATE (This item must be completed by applicant.)

I CERTIFY UNDER PENALTY OF LAW THAT THIS DOCUMENT AND ALL ATTACHMENTS WERE PREPARED IN CONFORMITY WITH THE NEW HAMPSHIRE RULES FOR THE CONTROL OF RADIATION UNDER MY DIRECTION OR SUPERVISION. THE INFORMATION SUBMITTED IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT THERE ARE SIGNIFICANT PENALTIES FOR SUBMITTING FALSE INFORMATION, INCLUDING THE POSSIBILITY OF FINE AND IMPRISONMENT FOR KNOWING VIOLATIONS.

_____
Signature of Authorized Signatory

_____
Name (type or print)

Date: _____

_____
Title

# TRAINING AND EXPERIENCE

☐ AUTHORIZED USER ☐ RADIATION SAFETY OFFICER

1. NAME OF AUTHORIZED USER OR RADIATION OFFICER

2. FORMAL TRAINING IN RADIATION SAFETY

| Field of Training | Location and Date(s) of Training | Hours of Training | |
|---|---|---|---|
| | | Lecture/ Laboratory Courses | Supervised Laboratory Experience |
| Radiation Physics and Instrumentation | | | |
| Principles and Practices of Radiation Protection | | | |
| Mathematics Pertaining to the Use and Measurement of Radioactivity | | | |
| Biological Effects of Radiation | | | |

3. EXPERIENCE WITH RADIATION
(Actual use of Radioisotopes or Equivalent Experience)

| Isotope | Maximum Amount | Where Experience Was Gained | Duration of Experience | Type of Use |
|---|---|---|---|---|
| | | | | |

# TRAINING AND EXPERIENCE

☐ **AUTHORIZED USER** ☐ **RADIATION SAFETY OFFICER**

1. NAME OF AUTHORIZED USER OR RADIATION SAFETY OFFICER

2. FORMAL TRAINING IN RADIATION SAFETY

| Field of Training | Location and Date(s) of Training | Extent of Training | |
|---|---|---|---|
| | | Course(s) (Hours) | Supervised Experience (Hours) |
| Radiation Physics and Instrumentation | | | |
| Principles and Practices of Radiation Protection | | | |
| Mathematics Pertaining to the Use and Measurement of Radioactivity | | | |
| Biological Effects of Radiation | | | |

3. EXPERIENCE WITH RADIATION
(Actual use of Radioactive Materials or Equivalent Experience)

| Isotope | Maximum Amount | Where Experience Was Gained | Duration of Experience (Years) | Type of Use |
|---|---|---|---|---|
| | | | | |

FORM DHHS/RHS-1.1

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## APPLICATION FOR ANNUAL RENEWAL OF RADIOACTIVE MATERIAL LICENSE

INSTRUCTIONS: Complete items 1 through 5. Mail the original to: ~~NH DHHS~~ Radiological Health Section, Division of Public Health Services, NH Department of Health and Human Services, 29 Hazen Drive, ~~Health and Welfare Building,~~ Concord, New Hampshire 03301~~-6503~~. Upon approval of an application, a Radioactive Material License may be renewed pursuant to statutory and implementing regulatory authority and subject to all applicable rules and orders of all appropriate regulatory agencies now or hereafter in effect and to any conditions specified in the license.

| 1a. NAME, ADDRESSES, TELEPHONE & FAX NUMBERS OF APPLICANT *(Include Physical & Mailing Addresses)* | 1b. ~~STREET~~ ADDRESS(ES) ~~AT WHICH~~WHERE RADIOACTIVE MATERIAL WILL BE USED/POSSESSED *(if different from 1a)* |
|---|---|
| Tel. (  ) _____ – __  Fax (  ) _____ | |
| 2. DEPARTMENT TO USE MATERIAL | 3. RADIOACTIVE MATERIAL LICENSE NUMBER |

4. It is requested that Radioactive Material License No. _____ be amended to extend the expiration date to _____.

5. CERTIFICATE~~:~~

I CERTIFY UNDER PENALTY OF LAW THAT THIS DOCUMENT AND ALL ATTACHMENTS WERE PREPARED IN CONFORMITY WITH THE NEW HAMPSHIRE RULES FOR THE CONTROL OF RADIATION UNDER MY DIRECTION OR SUPERVISION. THE INFORMATION SUBMITTED IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT THERE ARE SIGNIFICANT PENALTIES FOR SUBMITTING FALSE INFORMATION, INCLUDING THE POSSIBILITY OF FINE AND IMPRISONMENT FOR KNOWING VIOLATIONS.

_____
Signature of Authorized Signatory

_____
Name (type or print)

Date~~:~~ _____

_____
Title

FORM DHHS/RHS-1M

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## APPLICATION FOR RADIOACTIVE MATERIAL LICENSE – MEDICAL

INSTRUCTIONS: Complete items 1 through 27 of this application. Use supplemental sheets where necessary. Item 27 shall be completed on all applications. Mail the original and one copy of the application package to: ~~NH DHHS~~ Radiological Health Section, ~~Health and Welfare Building,~~Division of Public Health Services, NH Department of Health and Human Services, 29 Hazen Drive, Concord, New Hampshire 03301~~-6503~~. Upon approval of an application, the applicant shall receive a Radioactive Material License, issued pursuant to statutory and implementing regulatory authority, and subject to all applicable rules and orders of all appropriate regulatory agencies now or hereafter in effect and to any conditions specified in the license.

| | |
|---|---|
| 1a. NAME AND MAILING ADDRESS OF APPLICANT (institution, firm, clinic, physician, etc.)<br><br>Tel. # ( ) _____-_____ Fax # ( ) _____-_____ | 1b. ~~STREET~~ ADDRESS(ES) ~~AT WHICH~~WHERE RADIOACTIVE MATERIAL WILL BE USED/POSSESSED ~~(~~if different from 1a.) |
| 2. NAME OF PERSON TO CONTACT REGARDING THIS APPLICATION<br><br>Tel. # ( ) _____-_____<br>Email: | 3. THIS APPLICATION IS FOR: (Check appropriate item)<br>a. ☐ New license<br>b. ☐ Renewal of license no. _____ |
| 4. RADIATION SAFETY OFFICER (RSO) AND/OR ASSOCIATE RADIATION SAFETY OFFICER (ARSO) (Name of individual(s) and a completed Form DHHS/RHS-1M ~~person designated as radiation safety officer. If other than individual user, complete~~ Supplement A for each. ~~Resumé stating training and experience is optional.)~~ | 5. INDIVIDUAL USERS, MEDICAL PHYSICISTS OR NUCLEAR PHARMACISTS (Provide name(s) and submit the appropriate completed Form DHHS/RHS-1M~~Complete~~ Supplement B, C or D for each individual.) |

6a. RADIOACTIVE MATERIAL FOR MEDICAL USE

| RADIOACTIVE MATERIAL LISTED IN: | MARK ITEMS DESIRED "X" | MAXIMUM POSSESSION LIMITS (in m-Ci) |
|---|---|---|
| He-P 4035.27 Uptake, Dilution, or Excretion Studies | | As needed |
| He-P 4035.31 Imaging and Localization Studies | | As needed |
| He-P 4035.35 Radiopharmaceuticals for Therapy | | ~~As needed~~ |
| ADDITIONAL ITEMS: (List in Item 6b.) | | |
| Gaseous Radiopharmaceuticals ~~(List in Item 6b.)~~ | | N/A |
| Radiopharmaceuticals for In Vitro Use ~~(List in Item 6b.)~~ | | N/A |
| He-P 4035.29 Other Medical Uses of Byproduct Materials | | |

6b. RADIOACTIVE MATERIAL FOR USES NOT LISTED IN ITEM 6a.

| ELEMENT AND MASS NUMBER | CHEMICAL AND/OR PHYSICAL FORM | MAXIMUM NUMBER OF MILLICURIES OF EACH FORM | DESCRIBE PURPOSE OF USE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

INFORMATION REQUIRED FOR ITEMS 7 THROUGH 23

For items 7 through 23, check the appropriate box(es) and submit a detailed description of all the requested information. Begin each item on a separate sheet. Identify the item number and the date of the application in the lower right corner of each page. If you indicate that an appendix to the medical licensing guide will be followed, do not submit the pages, but specify the date of the referenced guide. *Page numbers indicated below refer to the page number of the "Guide for the Preparation of Application for Material License – Medical."*

7. RADIATION SAFETY COMMITTEE
   - ☐ Names and Specialties ~~A~~attached; AND
   - ☐ Duties in Appendix A; OR
   - ☐ Equivalent Duties ~~A~~attached

8. TRAINING AND EXPERIENCE
   - ☐ Supplement A ~~A~~attached for RSO
   - ☐ Supplement A attached for ARSO
   - ☐ Supplement B ~~A~~attached for Each Individual User;
   - ☐ Supplement C ~~A~~attached for Each Medical Physicist;
   - ☐ Supplement D ~~A~~attached for Each Nuclear Pharmacist

9. INSTRUMENTATION
   - ☐ Appendix F Form (Page 29~~30~~) ~~A~~attached; OR
   - ☐ List by Name and Model Number

10. CALIBRATION OF INSTRUMENTS

    SURVEY INSTRUMENTS
    - ☐ Appendix G Procedures ~~F~~followed and Pages 3~~4~~–3~~6~~ ~~A~~attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

    DOSE CALIBRATOR
    - ☐ Appendix G Procedures ~~F~~followed and Page 4~~0~~ ~~A~~attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

11. FACILITIES AND EQUIPMENT
    - ☐ Description and Diagram ~~A~~attached

12. PERSONNEL TRAINING PROGRAM
    - ☐ Description of Training ~~A~~attached

13. PROCEDURES FOR ORDERING AND RECEIVING RADIOACTIVE MATERIALS
    - ☐ Appendix H Followed and Page 4~~2~~3 ~~A~~attached; OR
    - ☐ Detailed Information ~~A~~ttached

14. PROCEDURES FOR SAFELY OPENING PACKAGES CONTAINING RADIOACTIVE MATERIALS
    - ☐ Appendix I Procedures ~~F~~followed and Page 4~~4~~5 ~~A~~attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

15. GENERAL RULES FOR THE SAFE USE OF RADIOACTIVE MATERIAL
    - ☐ Appendix J Rules ~~F~~followed; OR
    - ☐ Equivalent Procedures ~~A~~attached

16. EMERGENCY PROCEDURES
    - ☐ Appendix K Procedures ~~F~~followed and Page 4~~6~~7 ~~A~~attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

17. AREA SURVEY & WIPE PROCEDURES
    - ☐ Appendix L Procedures ~~F~~followed; OR
    - ☐ Equivalent Procedure(s) Attached

18. WASTE DISPOSAL
    - ☐ Appendix M Form (Page 4~~8~~9) ~~A~~attached; OR
    - ☐ Equivalent Information ~~A~~attached

19. THERAPEUTIC USE OF RADIOPHARMACEUTICALS
    - ☐ Appendix N Procedures ~~F~~followed and Page 5~~2~~3 ~~A~~attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

20. THERAPEUTIC USE OF SEALED SOURCES
    - ☐ Detailed Information ~~A~~attached; AND
    - ☐ Appendix O Procedures ~~F~~followed and Pages 5~~4~~5–5~~6~~7 Attached; OR
    - ☐ Equivalent Procedures ~~A~~attached

21. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE GASES AND AEROSOLS
    - ☐ Appendix P Procedures ~~F~~followed; OR
    - ☐ Equivalent Procedures ~~A~~attached

22. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE MATERIAL IN ANIMALS
    - ☐ Detailed Information ~~A~~attached

23. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE MATERIAL SPECIFIED IN ITEM 6b.
    - ☐ Detailed Information ~~A~~attached

24. PERSONNEL MONITORING DEVICES

| | Supplier | Exchange Frequency |
|---|---|---|
| a. WHOLE BODY (circle type) Film / TLD / OSL | | |
| b. FINGER (circle type) Film / TLD / OSL | | |
| c. WRIST | | |

d. OTHER (specify)

25. **FOR PRIVATE PRACTICE APPLICANTS ONLY**

a. HOSPITAL AGREEING TO ACCEPT PATIENTS CONTAINING RADIOACTIVE MATERIAL

NAME OF HOSPITAL

MAILING ADDRESS

CITY STATE ZIP CODE

b. Attach a copy of the agreement letter signed by the Hospital Administrator.

c. When requesting therapy procedures, attach a copy of radiation safety precautions to be taken and list available radiation detection instruments.

26. SPECIFIC LICENSE FEE (Refer to ~~Part~~Hc-P 4070, New Hampshire Rules for the Control of Radiation.)

Category~~:~~ _____ Amount Enclosed~~:~~ $_____

27. CERTIFICATE (This item must be completed by applicant.)

I CERTIFY UNDER PENALTY OF LAW THAT THIS DOCUMENT AND ALL ATTACHMENTS WERE PREPARED IN CONFORMITY WITH THE NEW HAMPSHIRE RULES FOR THE CONTROL OF RADIATION UNDER MY DIRECTION OR SUPERVISION. THE INFORMATION SUBMITTED IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT THERE ARE SIGNIFICANT PENALTIES FOR SUBMITTING FALSE INFORMATION, INCLUDING THE POSSIBILITY OF FINE AND IMPRISONMENT FOR KNOWING VIOLATIONS.

_____
Signature of Authorized Signatory

_____
Name (type or print)

Date~~:~~ _____

_____
Title

**FORM DHHS/RHS-1M**
Supplement A

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## RADIATION SAFETY OFFICER OR ASSOCIATE RADIATION SAFETY OFFICER TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

***(New Hampshire Rules for the Control of Radiation He-P 4035.61, He-P 4035.71)***

**Name of Proposedl~~Radiation Safety Officer~~ Individual** ☐ RSO ☐ ARSO

**Requested Authorized Use(s)** ~~*The license authorizes the following medical uses as defined in He-P 4035 (c*~~*Check all that apply~~)~~:*

☐ He- P 4035.27 Uptake, Dilution, and Excretion Studies

☐ He- P 4035.31 Imaging and Localization Studies

☐ He- P 4035.35Unsealed Byproduct Material–Written Directive Required Diagnosis

☐ He- P 4035.39 Use of Sealed Sources for Diagnosis

☐ He- P 4035.41 Manual Brachytherapy Sources

☐ He- P 4035.47 ~~Remote Afterloader~~ Gamma Stereotactic Radiosurgery Unit(s)

☐ He- P 4035.47 Remote Afterloader Unit(s)

☐ He- P 4035.47 Teletherapy Unit(s)

☐ He- P 4035.29 Other Medical Uses of Byproduct Material or Radiation from Byproduct Material

## PART I – TRAINING AND EXPERIENCE

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

a. Provide a copy of the board certification.

b. (i) If the board certification process has been recognized by the NRC and meets the requirements of He-P 4035.61, then ~~U~~use the table in section 3.c. to describe training in radiation safety, regulatory issues, and emergency procedures for all types of authorized medical use(s) on the license. **STOP** here.

~~c.~~ (ii) If board certification was issued on or before October 24, 2005 & is listed in He-P 4035.71; provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005. **STOP** here. ~~Skip to and complete Part II Preceptor Attestation.~~

**OR**

☐ **2. Current Radiation Safety Officer (RSO) or Associate Radiation Safety Officer (ARSO) Seeking Authorization to ~~B~~be Recognized as a RSO or ARSO ~~Radiation Safety Officer~~ for the Additional Medical Uses Checked Above**

a. Use the table in section 3.c. to describe training in radiation safety, regulatory issues, and emergency procedures for the additional types of medical use for which recognition as RSO or ARSO is sought.

b. If board certified, provide a copy of the certificate and STOP here. If not board certified, ~~S~~skip to and complete Part II Preceptor Attestation.

**OR**

☐ **3. Structured Educational Program for Proposed RSO or ARSO ~~Radiation Safety Officer~~**

a. Classroom and Laboratory Training

| Description of Training | Location of Training | Clock Hours | Dates of Training* |
|---|---|---|---|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of radioactivity | | | |

| | | | |
|---|---|---|---|
| Radiation biology | | | |
| Radiation dosimetry | | | |

**Total Hours of Training:** _____

**3. Structured Educational Program for Proposed RSO or ARSO ~~Radiation Safety Officer~~ (continued)**

b. Supervised Radiation Safety Experience *(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)*

| Description of Experience | Location of Experience/ License or Permit Number of Facility | Dates of Training* |
|---|---|---|
| Shipping, receiving, and performing related radiation surveys | | |
| Using and performing checks for proper operation of instruments used to determine the activity of dosages, survey meters, and instruments used to measure radionuclides | | |
| Securing and controlling byproduct material | | |
| Using administrative controls to avoid mistakes in administration of byproduct material | | |
| Using procedures to prevent or minimize radioactive contamination and using proper decontamination procedures | | |
| Using emergency procedures to control byproduct material | | |
| Disposing of byproduct material | | |
| Licensed Material Used (e.g., 4035.27, 4035.31, etc.+) _____ _____ _____ _____ | | |

+ Choose all applicable sections of He-P 4035 to describe radioisotopes and quantities used: He-P 4035.27, He-P 4035.31, He-P 4035.35, He-P 4035.39, He-P 4035.41, He-P 4035.47 remote afterloader units, He-P 4035.47 teletherapy units, He-P 4035.47 gamma stereotactic radiosurgery units, and He-P 4035.29 emerging technologies (provide list of devices).

| **Supervising Individual~~:~~** | **License/Permit number listing supervising individual as a Radiation Safety Officer or Associate Radiation Safety Officer** |
|---|---|
| | |

**This license authorizes the following medical uses (check all that apply)*:***

- ☐ He- P 4035.27 Uptake, Dilution, and Excretion Studies
- ☐ He-P 4035.31 Imaging and Localization Studies
- ☐ He-P 4035.35 Unsealed Byproduct Material–Written Directive Required
- ☐ He-P 4035.39 Use of Sealed Sources for Diagnosis
- ☐ He-P 4035.41 Manual Brachytherapy Sources
- ☐ He-P 4035.47 Gamma Stereotactic Radiosurgery Unit(s)
- ☐ He-P 4035.47 Remote Afterloader Unit(s)
- ☐ He-P 4035.47 Teletherapy Unit(s)
- ☐ He-P 4035.29 Other Medical Uses of Byproduct Material or Radiation from Byproduct Material

**3. Structured Educational Program for Proposed RSO or ARSO ~~Radiation Safety Officer~~ (continued)**

c. Describe training in radiation safety, regulatory issues, and emergency procedures for all types of medical use on the license.

| Description of Training | Training Provided By | Dates of Training* |
|---|---|---|
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P He-P 4035.27, He-P 4035.31, He-P 4035.39 uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.35 uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.41 uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.47 – teletherapy uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.47 – remote afterloader uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.47 – gamma stereotactic radiosurgery uses | | |
| Radiation safety, regulatory issues, and emergency procedures ~~described under~~for He-P 4035.29; specify use(s): | | |

**Supervising Individual** – ~~*If training was provided by supervising RSO, AU, AMP, or ANP.*~~*(If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

**License/Permit number listing supervising individual~~:~~**

**License/Permit lists supervising individual as:**

☐ Radiation Safety Officer ☐ Associate Radiation Safety Officer~~Authorized User~~ ~~☐ Authorized Medical Physicist~~ ~~☐ Authorized Nuclear Pharmacist~~

☐ Authorized User ☐ Authorized Medical Physicist ☐ Authorized Nuclear Pharmacist

Authorized ~~as RSO, AU, AMP, or ANP~~ for the following medical uses (check all that apply):

☐ He-P 4035.27 Uptake, Dilution, and Excretion Studies ☐ He-P 4035.31 Imaging and Localization Studies

☐ He-P 4035.35 Unsealed Byproduct Material–Written Directive Required ☐ He-P 4035.39 Use of Sealed Sources for Diagnosis

☐ He-P 4035.41 Manual Brachytherapy Sources ☐ He-P 4035.47 Gamma Stereotactic Radiosurgery Unit(s)

☐ He-P 4035.47 Remote Afterloader~~-~~ Unit(s) ☐ He-P 4035.47 Teletherapy Unit(s)

☐ He-P 4035.29 Other Medical Uses of Byproduct Material or Radiation from Byproduct Material

d. Skip to and complete Part II Preceptor Attestation.

**OR**

☐ **4. Authorized User, Authorized Medical Physicist, or Authorized Nuclear Pharmacist Identified on the Licensee's License**

a. Provide license number.

b. Use the table in section 3.c. to describe training in radiation safety, regulatory issues, and emergency procedures for all types of medical use on the license.

c. If board certified, provide a copy of the certificate and **STOP** here. If not board certified, skip to and ~~C~~complete Part II Preceptor Attestation.

---

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The ~~radiation safety officer~~ preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**FIRST SECTION** ~~– **Check one of the following**~~**:**

☐ ~~**1. Board Certification**~~

~~I attest that _____ has satisfactorily completed the requirements in~~
~~*Name of Proposed Radiation Safety Officer*~~

~~He-P 4035.61(a)(1) and (a)(2); or 4035.61(a)(4) and (a)(5); or 4035.61(b)(3)~~

~~**OR**~~

☐ ~~**2.**~~ **Structured Educational Program for Proposed RSO or ARSO~~Radiation Safety Officers~~**

I attest that _____ has satisfactorily completed the training and experience
*Name of Proposed RSO / ARSO~~Radiation Safety Officer~~*

as required by He-P 4035.61(b)(1) and (b)(2).

~~**OR**~~

☐ ~~**3. Additional Authorization as Radiation Safety Officer**~~

~~I attest that _____ is an~~
~~*Name of Proposed Radiation Safety Officerr*~~

~~*Check one of the following:* ☐ Authorized User ☐ Authorized Medical Physicist ☐ Authorized Nuclear Pharmacist~~

~~identified on the licensee's license and has experience with the radiation safety aspects of similar type of use of byproduct material for which the individual has Radiation Safety Officer responsibilities.~~

---

**AND**

**SECOND SECTION** ~~– **Complete for all submittals.**~~

☐ I attest that _____ has training in the radiation safety, regulatory issues, and
*Name of Proposed RSO / ARSO~~Radiation Safety Officer~~*

emergency procedures for the following types of use *(check all that apply)*:

- ☐ He-P 4035.27 Uptake, dilution, and excretion studies
- ☐ He-P 4035.31 Imaging and localization studies
- ☐ He-P 4035.35 Oral administration of less than or equal to 33 millicuries of sodium iodide I-131 for which a written directive is required
- ☐ He-P 4035.35 Oral administration of greater than 33 millicuries of sodium iodide I-131
- ☐ He-P 4035.35 Parenteral administration of any beta-emitter, or a photon-emitting radionuclide with a photon energy less than 150 keV for which a written directive is required
- ☐ He-P 4035.35 Parenteral administration of any other radionuclide for which a written directive is required
- ☐ He-P 4035.39 Use of sealed sources for diagnosis
- ☐ He-P 4035.41 Manual brachytherapy sources
- ☐ He-P 4035.47 Remote afterloader units
- ☐ He-P 4035.47 Teletherapy units
- ☐ He-P 4035.47 Gamma stereotactic radiosurgery units
- ☐ He-P 4035.29 Emerging technologies, including: _____

_____

_____

**AND**

**THIRD SECTION** – ~~**Complete for all submittals**~~**.**

☐ I attest that _____ has achieved a level of radiation safety knowledge
*Name of Proposed RSO / ARSO~~Radiation Safety Officer~~*

sufficient to function independently as: ☐ A ~~a~~ Radiation Safety Officer for a medical use licensee.

**OR**

☐ An Associate Radiation Safety Officer for a medical use licensee.

~~**AND**~~

**FOURTH SECTION** –

☐ I am the Radiation Safety Officer for ☐ I am the Associate Radiation Safety Officer for

Name of Facility _____ License/Permit Number _____

~~I am the Radiation Safety Officer for:~~ _____
~~*Name of Facility*~~

~~License/Permit Number:~~ _____

| | |
|---|---|
| **Name of Preceptor~~:~~** | **Telephone Number~~:~~** |
| **Signature~~:~~** | **Date~~:~~** |

**FORM DHHS/RHS-1M**
Supplement B-Diagnostic

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## AUTHORIZED USER TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

***(~~For uses defined under~~ New Hampshire Rules for the Control of Radiation He-P 4035.6327, He-P 4035.64,~~31~~ He-P 4035.68 & He-P 4035.7139)***

| **Name of Proposed Authorized User~~:~~** | **State or Territory Where Licensed~~:~~** |
|---|---|
| | |

**Requested Authorized~~ation~~ Use(s) –** ***Check all that apply:***

- ☐ He-P 4035.27 Uptake, Dilution, and Excretion Studies
- ☐ He-P 4035.31 Imaging and Localization Studies
- ☐ He-P 4035.39 Use of Sealed Sources for Diagnosis (Specify device(s): _____)

## PART I – TRAINING AND EXPERIENCE
***(He-P 4035.63, He-P 4035.64 & He-P 4035.7168)***

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

a. Provide a copy of the board certification.

b. If using only 4035.39 materials, use the table in Section 3.c to document specific training. ~~stop here. If using 4035.27 and 4035.31 materials, skip to and complete Part II Preceptor Attestation.~~

c. If the board certification was issued on or before October 24, 2005 and is listed in He-P 4035.71; provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005 and is compliant with He-P 4035.73.

d. **STOP** here.

**OR**

☐ **2. Current He-P 4035.65 Authorized User Seeking Additional He-P 4035.3164 Authorized~~ation~~ Use(s)**

a. Authorized user on Materials License _____ meeting He-P 4035.65, He-P 4035.71, or equivalent U.S. Nuclear Regulatory Commission (NRC) or Agreement State requirements seeking authorization for He-P 4035.3164 use.

b. Supervised Work Experience. *(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)*

| **Description of Experience** | **Location of Experience/ License or Permit Number of Facility** | **No. of~~Clock~~ Hours** | **Dates of Experience*** |
|---|---|---|---|
| Eluting generator systems appropriate for the preparation of radioactive drugs for imaging and localization studies, measuring and testing the eluate for radionuclidic purity, and processing the eluate with reagent kits to prepare labeled radioactive drugs | | | |

**Total Hours of Experience:** _____

| **Supervising Individual** | **License/Permit Number listing supervising individual as an authorized user or authorized nuclear pharmacist (ANP)** |
|---|---|
| | |

Supervisor meets the requirements below or equivalent NRC ~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements *(check all that apply)*:

☐ He-P 4035.64 ☐ He-P 4035.65 + He-P 4035.64 generator experience ~~in 4035.64(c)(1)b.7.~~ ☐ He-P 4035.71 ☐ He-P 4035.74 ANP

c. If board certified, provide copy of certificate and **STOP** here. If not, skip to and complete Part II Preceptor Attestation.

**OR**

**3. Training and Experience for Proposed Authorized User**

a. Classroom and Laboratory Training

| Description of Training | Location of Training | No. of~~Clock~~ Hours | Dates of Training* |
|---|---|---|---|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of radioactivity | | | |
| Chemistry of byproduct material for medical use *(not required for He-P 4035.68)* | | | |
| Radiation biology | | | |

**Total Hours of Training~~:~~** _____

b. Supervised Work Experience - **Total Hours of Experience**

~~(~~Completion of this table is not required for He-P 4035.68.~~)~~ *(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)*

~~**Total Hours of Experience:** _____~~

| Description of Experience Must Include | Location of Experience/ License or Permit Number of Facility | Confirm | Dates of Experience* |
|---|---|---|---|
| Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys | | ☐ Yes ☐ No | |
| Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters | | ☐ Yes ☐ No | |
| Calculating, measuring, and safely preparing patient or human research subject dosages | | ☐ Yes ☐ No | |
| Using administrative controls to prevent a medical event involving the use of unsealed byproduct material | | ☐ Yes ☐ No | |
| Using procedures to contain spilled byproduct material safely and using proper decontamination procedures | | ☐ Yes ☐ No | |
| Administering dosages of radioactive drugs to patients or human research subjects | | ☐ Yes ☐ No | |
| Eluting generator systems appropriate for the preparation of radioactive drugs for imaging and localization studies, measuring and testing the eluate for radionuclidic purity, and processing the eluate with reagent kits to prepare labeled radioactive drugs | | ☐ Yes ☐ No | |

| **Supervising Individual** | **License/Permit number listing supervising individual as an authorized user** |
|---|---|
| | |

Supervisor meets the requirements below, or equivalent NRC~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements *(check one):* ☐ He-P 4035.63 ☐ He-P 4035.64 ☐ He-P 4035.65 ~~+~~ + He-P 4035.65~~4~~ ~~and~~ generator experience ~~in 4035.64(e)(1)b.7.~~

**3. Training and Experience for Proposed Authorized User (continued)**

c. For He-P 4035.68 only, provide documentation of training on use of the device.

| Device | Type of Training | Location and Dates* |
|---|---|---|
| | | |
| | | |

d. For He-P 4035.39 uses only, ~~stop~~**STOP** here. For He-P 4035.27 and He-P 4035.31 uses, complete Part II Preceptor Attestation.

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each~~:~~. ~~(N~~not required to meet He-P 4035.68 training requirements ~~in 4035.68.)~~

By checking the boxes below, the preceptor is attesting that the individual has knowledge to fulfill the duties of the position sought and not attesting to the individual's "general clinical competency."

**FIRST SECTION – Check one of the following for each use requested:**

☐ **For 4035.63~~:~~** ☐ **~~1.Board Certification~~**

I attest that _____ has satisfactorily completed the
*Name of Proposed Authorized User*

training and experience requirements in He-P 4035.63~~(a)(1)~~ and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under He-P 4035.27.

**~~OR~~**

☐ **~~2. Training and Experience~~**

☐ **For He-P 4035.64** I attest that _____ has satisfactorily completed the training
*Name of Proposed Authorized User*

and experience require~~d~~ments in ~~by~~ He-P 4035.63~~4(c)(1),~~ and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under He-P 4035.27 and He-P 4035.31.

**~~For 4035.64:~~** ☐ **~~1. Board Certification~~**

~~I attest that _____ has satisfactorily completed the~~
~~*Name of Proposed Authorized User*~~
~~requirements in He-P 4035.64(b)(1) and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under 4035.27 and 4035.31.~~

**~~OR~~**

☐ **~~2. Training and Experience~~**

~~I attest that _____ has satisfactorily completed the training~~
~~*Name of Proposed Authorized User*~~
~~and experience, required by 4035.64(c)(1), and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under 4035.27 and 4035.31.~~

## AND

**SECOND SECTION – Complete one of the following for attestation and signature:~~for all submittals.~~**

Authorized User

☐ I meet the requirements below, or equivalent ~~U.S. Nuclear Regulatory Commission~~NRC or Agreement State requirements, as an authorized user for~~ the following~~:

☐ He-P 4035.63 ☐ He-P 4035.64 ☐ He-P 4035.65~~ +~~ ☐ He-P 4035.6~~45 an~~d generator experience

## OR

Residency Program Director

☐ I affirm that the attestation represents the consensus of the residency program faculty where at least one faculty member is an authorized user who meets the requirements below or equivalent NRC or Agreement State requirements, as an authorized user for: ☐ He-P 4035.63 ☐ He-P 4035.64 ☐ He-P 4035.65 + He-P 4035.64 generator experience

☐ I affirm that this facility member concurs with the attestation I am providing as program director.

☐ I affirm that the residency training program is approved by the:

☐ Residency Review Committee of the Accreditation Council for Graduate Medical Education; or

☐ Royal College of Physicians and Surgeons of Canada; or

☐ Council on Post-Graduate Training of the American Osteopathic Association.

☐ I affirm that the residency training program includes training & experience specified in: ☐ He-P 4035.63 ☐ He-P 4035.64

| **Name of Preceptor~~:~~** | **Signature~~:~~** | **Telephone Number~~:~~** | **Date~~:~~** |
|---|---|---|---|
| | | | |

**~~License/Permit Number/~~Facility Name~~:~~** _____ **License/Permit Number**

**FORM DHHS/RHS-1M**
Supplement B-Sources

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## AUTHORIZED USER TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

*(~~For uses defined under~~ New Hampshire Rules for the Control of Radiation He-P 4035.5941, He-P 4035.67, He-P 4035.69 & He-P 4035.471)*

| **Name of Proposed Authorized User~~:~~** | **State or Territory Where Licensed~~:~~** |
|---|---|
| | |

**Requested Authorizedation~~ation~~ Use(s) –** ***Check all that apply:***

☐ He-P 4035.41 Manual brachytherapy sources

☐ ~~4035.41 Ophthalmic use of strontium-90~~

☐ He-P 4035.417 Ophthalmic use of strontium-90~~Gamma stereotactic radiosurgery unit(s)~~

☐ He-P 4035.47 Teletherapy unit(s)~~Remote afterloader unit(s)~~

☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)

☐ He-P 4035.47 Remote afterloader unit(s)

## PART I – TRAINING AND EXPERIENCE

***(He-P 4035.59, He-P4035.67, ~~&~~ He-P 4035.69 and He-P 4035.71)***

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

a. Provide a copy of the board certification.

b. For He-P 4035.4759, go to the table in 3.a. and describe training provider and dates of training for each type of use for which authorization is sought.

c. If the board certification was issued on or before October 24, 2005 and is listed in He-P 4035.71; provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005 and is compliant with He-P 4035.73.~~Skip to and complete Part II Preceptor Attestation.~~

d. **STOP** here.

**OR**

☐ **2. Current He-P 4035.47 Authorized User Seeking~~Requesting~~ Additional Authorization for He-P 4035.47 Use(s) Checked Above**

a. Go to the table in section 3.a. to document training for new device.

b. If board certified, provide a copy and **STOP** here. If not, ~~S~~skip to and complete Part II Preceptor Attestation.

**OR**

☐ **3. Training and Experience for Proposed Authorized User**

a. For He-P 4035.47 uses, describe training provider and dates of training for each type of ~~use for which~~ authorizedation ~~is sought~~ use requested.

| **Description of Training** | **Training Provider and Dates** | | |
|---|---|---|---|
| | **Remote Afterloader** | **Teletherapy** | **Gamma Stereotactic Radiosurgery** |
| Device operation | | | |
| Safety procedures for the device use | | | |
| Clinical use of the device | | | |

| **Supervising Individual** – *If training was provided by Supervising Individual. (If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)* | **License/Permit number listing supervising individual as an authorized user** |
|---|---|
| Authorized for the following types of use:<br>☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s) | |

**3. Training and Experience for Proposed Authorized User (continued)**

b. Classroom ~~&~~and Laboratory Training *(Check all that apply):* ☐ He-P 4035.59 ☐ He-P 4035.67 ☐ He-P 4035.69

| Description of Training | Location of Training | ~~Clock~~No. of Hours | Dates of Training* |
|---|---|---|---|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of radioactivity | | | |
| Radiation biology | | | |

**Total Hours of Training:** _____

c. Supervised Work ~~&~~and Clinical Experience for He-P 4035.59 **Total Hours of Experience** _____

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

~~**Total Hours of Experience:** _____~~

| Description of Experience Must Include | Location of Experience/ License or Permit Number of Facility | Confirm | Dates of Experience* |
|---|---|---|---|
| Reviewing full calibration measurements and periodic spot-checks | | ☐ Yes ☐ No | |
| Preparing treatment plans and calculating treatment doses and times | | ☐ Yes ☐ No | |
| Using administrative controls to prevent a medical event involving the use of byproduct material | | ☐ Yes ☐ No | |
| Implementing emergency procedures to be followed in the event of the abnormal operation of the medical unit or console | | ☐ Yes ☐ No | |
| Checking and using survey meters | | ☐ Yes ☐ No | |
| Selecting the proper dose and how it is to be administered | | ☐ Yes ☐ No | |

| Clinical experience in radiation oncology as part of an approved formal training program | Location of Experience/ License or Permit Number of Facility | Dates of Experience* |
|---|---|---|
| **Approved by:**<br>☐ Residency Review Committee for Radiation Oncology of the ACGME<br>☐ Royal College of Physicians and Surgeons of Canada<br>☐ Committee on Postdoctoral Training of the American Osteopathic Association | | |

| Supervising Individual | License/Permit number listing supervising individual as an authorized user |
|---|---|
| | |

**3. Training and Experience for Proposed Authorized User (continued)**

d. Supervised Clinical ~~Case~~ Experience He-P 4035.67

| Description of Experience | Location of Experience/License or Permit Number of Facility | No. of ~~Clock~~ Hours | Dates of Experience* |
|---|---|---|---|
| Use of strontium-90 for ophthalmic treatment, including:<br>Examination of each individual to be treated;<br>Calculation of the dose to be administered;<br>Administration of the dose; and<br>Follow up and review of each individual's case history | | | |

| Supervising Individual | License/Permit number listing supervising individual as an authorized user |
|---|---|
| | |

e. Supervised Work and Clinical Experience for He- P 4035.69 **Total Hours of Experience:** _____

*(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)*

~~**Total Hours of Experience:** _____~~

| Description of Experience Must Include | Location of Experience/ License or Permit Number of Facility | Confirm | Dates of Experience* |
|---|---|---|---|
| Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys | | ☐ Yes ☐ No | |
| Checking survey meters for proper operation | | ☐ Yes ☐ No | |
| Preparing, implanting, and safely removing brachytherapy sources | | ☐ Yes ☐ No | |
| Maintaining running inventories of material on hand | | ☐ Yes ☐ No | |
| Using administrative controls to prevent a medical event involving the use of ~~unsealed~~ byproduct material | | ☐ Yes ☐ No | |
| Using emergency procedures to control byproduct material | | ☐ Yes ☐ No | |

| Clinical experience in radiation oncology as part of an approved formal training program | Location of Experience/ License or Permit Number of Facility | Dates of Experience* |
|---|---|---|
| **Approved by:**<br>☐ Residency Review Committee for Radiation Oncology of the ACGME<br>☐ Royal College of Physicians and Surgeons of Canada<br>☐ Committee on Postdoctoral Training of the American Osteopathic Association | | |

| Supervising Individual | License/Permit number listing supervising individual as an authorized user |
|---|---|
| | |

f. Complete Part II Preceptor Attestation.

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each. ~~(Not required to meet training requirements in 4035.68.)~~

By checking the boxes below, the preceptor is attesting that the individual has knowledge to fulfill the duties of the position sought and not attesting to the individual's "general clinical competency."

**FIRST SECTION – Check one of the following for each requested authorization:**

**For He-P 4035.59:**

☐ ~~1. Board Certification~~

~~I attest that _____ has satisfactorily completed the requirements in 4035.59(a).~~
~~*Name of Proposed Authorized User*~~

**~~OR~~**

☐ ~~Training and Experience~~

I attest that _____ has satisfactorily completed the training, supervised work
*Name of Proposed Authorized User*

~~and~~ experience and 3 years of supervised clinical experience in radiation therapy as required by He-P 4035.59(b)~~(1), (b)(2) and (b)(3)~~.

**AND**

☐ I attest that _____ has received training required in He-P 4035.59(c) for device
*Name of Proposed Authorized User*

operation, safety procedures, and clinical use for the type(s) of use for which authorization is sought, as checked below:

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

---

**For He-P 4035.67:**

☐ I attest that _____ has satisfactorily completed the classroom and laboratory
*Name of Proposed Authorized User*

training and the supervised clinical training, which includes the use of strontium-90 for the ophthalmic treatment of 5 individuals, ~~experience~~ as required by He-P 4035.67~~(a)(2), and has achieved a level of competency sufficient to function independently as an authorized user of strontium-90~~ for the ophthalmic use of strontium-90.

---

**For He-P 4035.69:** ☐ ~~1. Board Certification~~

☐ I attest that _____ has satisfactorily completed the training, supervised work experience~~requirements in 4035.69~~
*Name of Proposed Authorized User*

and 3 years of supervised clinical experience in radiation oncology as required by~~in~~ He-P 4035.69(~~a~~b)~~(1) and has achieved a level of competency sufficient to function independently as an authorized user~~ for the medical use of manual brachytherapy sources ~~for the medical uses authorized under 4035.41~~.

**~~OR~~**

☐ ~~2. Training and Experience~~

~~I attest that _____ has satisfactorily completed the training and~~
~~*Name of Proposed Authorized User*~~
~~experience as required by 4035.69(b), and has achieved a level of competency sufficient to function independently as an authorized user of manual brachytherapy sources for the medical uses authorized under 4035.41.~~

**AND**

**SECOND SECTION** ~~— Complete for all submittals~~**.**

☐ I attest that _____ has achieved a level of competency sufficient to ~~function~~
*Name of Proposed Authorized User*
independently fulfill the radiation safety-related duties as an authorized user for: *(Check all that apply)*

~~☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)~~

☐ He-P 4035.41 Manual brachytherapy sources
☐ He-P 4035.41 Ophthalmic use of strontium-90
☐ He-P 4035.47 Remote afterloader unit(s)
☐ He-P 4035.47 Teletherapy unit(s)
☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)

**AND**

**THIRD SECTION** ~~— Complete for all submittals.~~

Authorized User

☐ I meet the requirements in He-P 4035.59, He-P 4035.67, He-P 4035.69, or equivalent NRC ~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements~~,~~ as an authorized user for the following:

☐ He-P 4035.41 Manual brachytherapy sources
☐ He-P 4035.41 Ophthalmic use of strontium-90
☐ He-P 4035.47 Remote afterloader unit(s)
☐ He-P 4035.47 Teletherapy unit(s)
☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)
☐ He-P 4035.71 for He-P 4035.41 and/or 4035.47 uses, as applicable

**OR**

Residency Program Director (for He-P 4035.59 and/or 4035.69 only)

☐ I affirm that the attestation represents the consensus of the residency program faculty where at least one faculty member is an authorized user who meets the following requirements or equivalent NRC or Agreement State requirements:

☐ He-P 4035.41 Manual brachytherapy sources
☐ He-P 4035.47 Remote afterloader unit(s)
☐ He-P 4035.47 Teletherapy unit(s)
☐ He-P 4035.47 Gamma stereotactic radiosurgery unit(s)
☐ He-P 4035.71 for He-P 4035.41 and/or 4035.47 uses, as applicable

☐ I affirm that this facility member concurs with the attestation I am providing as program director.

☐ I affirm that the residency training program is approved by the:

☐ Residency Review Committee of the Accreditation Council for Graduate Medical Education; or
☐ Royal College of Physicians and Surgeons of Canada; or
☐ Council on Post-Graduate Training of the American Osteopathic Association.

| **Name of Preceptor~~:~~** | **Signature~~:~~** | **Telephone Number~~:~~** | **Date~~:~~** |
|---|---|---|---|
| | | | |

~~**License/Permit Number/**~~**Facility Name** _____ **License/Permit Number/~~:~~**

**FORM DHHS/RHS-1M**
Supplement B-Therapy

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## AUTHORIZED USER TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

***(~~For uses defined under~~ New Hampshire Rules for the Control of Radiation He-P 4035.~~3~~6~~5~~5, He-P 4035.66 & He-P 4035.71)***

| **Name of Proposed Authorized User~~:~~** | **State or Territory Where Licensed~~:~~** |
|---|---|
| | |

**Requested Authorized~~ation~~ Use(s) –** ***Check all that apply:***

☐ He-P 4035.35 Use of Unsealed Byproduct Material for which a Written Directive is Required

**OR**

☐ He-P 4035.35 Oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 1.22 gigabecquerels (33 millicuries)

☐ He-P 4035.35 Oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 1.22 gigabecquerels (33 millicuries)

☐ He-P 4035.35 Parenteral administration of any radioactive drug that contains a radionuclide that is primarily used for its electron emission, beta-radiation characteristics, alpha radiation characteristics, ~~emitter or photon-emitting radionuclide with a~~ or photon energy of less than 150 keV for which a written directive is required

☐ ~~4035.35 Parenteral administration of any other radionuclide for which a written directive is required~~

## PART I – TRAINING AND EXPERIENCE
***(He-P 4035.65, ~~&~~ He-P 4035.66 & He-P 4035.71)***

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

a. Provide a copy of the board certification.

~~b~~ i. ~~.~~ For He-P 4035.65, provide documentation on supervised clinical case experience. The table in section 3.c. may be used to document this experience.

~~c.~~ii. For He-P 4035.66 (Parenteral), provide documentation on classroom and laboratory training, supervised work experience, and supervised clinical case experience. The tables in sections 3.a., ~~3.~~b., and ~~3.~~c. may be used to document this experience. Skip to and complete Par II Preceptor Attestation.

~~d. Skip to and complete Part II Preceptor Attestation.~~

b. If the board certification was issued on or before October 24, 2005 and is listed in He-P 4035.71(c)(2); provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005 and is compliant with He-P 4035.73.

c. **STOP** here.

**OR**

☐ **2. Current He-P 4035.35, He-P 4035.41, or He-P 4035.47 Authorized User Seeking Additional Authorized Use(s)~~ation~~**

a. Authorized user on Materials License _____ under the requirements below or equivalent U.S. Nuclear Regulatory Commission (NRC) or Agreement State requirements *(check all that apply):*

☐ He-P 4035.59 ☐ He-P 4035.65 ☐ He-P 4035.69 ~~66 (<33 mCi I-131)~~
☐ He-P 4035.66 (<33 mCi I-131) ~~(>33 mCi I-131)~~ ☐ He-P 4035.66 (>33 mCi I-131)
~~4035.69~~

b. If currently authorized for a subset of clinical uses under He-P 4035.35, provide documentation on additional required supervised case experience. The table in section 3.c. may be used to document this experience. If board certified, provide a copy and **STOP** here. If not board certified, skip to and ~~Also provide~~ complete~~d~~ Part II Preceptor Attestation.

c. If currently authorized under He-P 4035.59 or He-P 4035.69 or has board certification that is recognized by He-P 4035.59 or He-P 4035.69 and is ~~and~~ requesting authorization for He-P 4035.66 (Parenteral), provide documentation on classroom and laboratory training, supervised work experience, and supervised clinical case experience. The tables in sections 3.a., ~~3.~~b., and ~~3.~~c. may be used to document this experience. Skip to and ~~Also provide~~ complete~~d~~ Part II Preceptor Attestation.

**OR**

**3. Training and Experience for Proposed Authorized User**

a. Classroom and Laboratory Training *(Check all that apply)*

☐ He-P 4035.65 ☐ He-P 4035.66 (≤33 mCi I-131) ☐ He-P 4035.66 (>33 mCi I-131) ☐ He-P 4035.66 (Parenteral)

| Description of Training | Location of Training | ~~Clock~~ No. of Hours | Dates of Training* |
|---|---|---|---|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of radioactivity | | | |
| Chemistry of byproduct material for medical use | | | |
| Radiation biology | | | |

**Total Hours of Training:** _____

b. Supervised Work Experience

☐ He-P 4035.65 ☐ He-P 4035.66 (≤33 mCi I-131) ☐ He-P 4035.66 (>33 mCi I-131) ☐ He-P 4035.66 (Parenteral)

*(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)*

~~**Total Hours of Experience:** _____~~

| Description of Experience Must Include | Location of Experience/ License or Permit Number of Facility | Confirm | Dates of Experience* |
|---|---|---|---|
| Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys | | ☐ Yes ☐ No | |
| Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters | | ☐ Yes ☐ No | |
| Calculating, measuring, and safely preparing patient or human research subject dosages | | ☐ Yes ☐ No | |
| Using administrative controls to prevent a medical event involving the use of unsealed byproduct material | | ☐ Yes ☐ No | |
| Using procedures to contain spilled byproduct material safely and using proper decontamination procedures | | ☐ Yes ☐ No | |

| **Supervising Individual** | **License/Permit number listing supervising individual as an authorized user** |
|---|---|

Supervisor~~ing individual~~ meets the requirements below~~,~~ or equivalent NRC~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements *(check all that apply)***:

☐ He-P 4035.65
☐ He-P 4035.66~~(a)~~
☐ He-P 4035.66~~(d)~~
☐ He-P 4035.66~~(i)~~
☐ He-P 4035.71

With experience~~, that includes at least 3 cases of,~~ administering dosages of:

☐ Oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 1.22 gigabecquerels (33 millicuries)

☐ Oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 1.22 gigabecquerels (33 millicuries)

☐ Parenteral administration of any radioactive drug that contains a ~~beta emitter or photon emitting~~ radionuclide that is primarily used for its electron emission, beta characteristics, alpha radiation characteristics, or ~~with a~~ photon energy of less than 150 keV, ~~and/or parenteral administration of any other radionuclide,~~ for which a written directive is required

** Supervising authorized user must have experience in administering dosages in the same dosage category or categories as the individual requesting authorized user status.

**3. Training and Experience for Proposed Authorized User (continued)**

c. Supervised Clinical Case Experience (must include patient administration of dosages for at least 3 cases per use requested)
*(If more than one supervising individual is necessary to document supervised work experience ~~,~~ ~~provide multiple copies of this section.~~)*

| Description of Experience | Number of Cases Involving Personal Participation | Location of Experience/License or Permit Number of Facility | Dates of Experience* |
|---|---|---|---|
| Oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 1.22 gigabecquerels (33 millicuries) | | | |
| Oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 1.22 gigabecquerels (33 millicuries) | | | |
| Parenteral administration of any radioactive drug that contains a radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation characteristics, or ~~emitter or photon-emitting radionuclide with a~~ photon energy of less than 150 keV, for which a written directive is required | | | |
| ~~Parenteral administration of any other radionuclide for which a written directive is required (list radionuclides)~~ _____ | | | |

| **Supervising Individual** | **License/Permit number listing supervising individual as an authorized user** |
|---|---|

Supervisor~~ing individual~~ meets the requirements below~~,~~ or equivalent NRC~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements *(check all that apply)***:

☐ He-P 4035.65
☐ He-P 4035.66~~(a)~~
☐ He-P 4035.66~~(d)~~
☐ He-P 4035.66~~(i)~~
☐ He-P 4035.71

With experience~~, that includes at least 3 cases of,~~ administering dosages of:

☐ Oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 1.22 gigabecquerels (33 millicuries)
☐ Oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 1.22 gigabecquerels (33 millicuries)
☐ Parenteral administration of any radioactive drug that contains a radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation characteristics, ~~emitter~~ or ~~photon-emitting radionuclide with a~~ photon energy of less than 150 keV~~, and/or parenteral administration of any other radionuclide~~, for which a written directive is required

** Supervising authorized user must have experience in administering dosages in the same dosage category or categories as the individual requesting authorized user status.

d. Provide completed Part II Preceptor Attestation.

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each. ~~(Not required to meet training requirements in 4035.68.)~~

By checking the boxes below, the preceptor is attesting that the individual has knowledge to fulfill the duties of the position sought and not attesting to the individual's "general clinical competency."

**FIRST SECTION – Check one of the following for each ~~requested~~ authorization requested:**

☐ **For He-P 4035.65:** ~~☐ 1. Board Certification~~

I attest that _____ has satisfactorily completed the training and
*Name of Proposed Authorized User*
experience required~~ments in~~ by He-P 4035.65~~(b)(1).~~

**~~OR~~**

~~☐ 2. Training and Experience~~

☐ For He-P 4035.66 I attest that _____ has satisfactorily completed the training and
*Name of Proposed Authorized User*
~~and~~ experience ~~as~~ required by 4035.66~~5~~(b~~e~~)( (<33 mCi I-131).

☐ For He-P 4035.66 I attest that _____ has satisfactorily completed the training and
*Name of Proposed Authorized User*
experience required by 4035.66(e)( (>33 mCi I-131).

---

~~**For 4035.66 (Identical Attestation Statement Regardless of Training and Experience Pathway):**~~

☐ For He-P 4035.66 I attest that _____ has satisfactorily completed the training and~~as required~~
*Name of Proposed Authorized User*
experience required by ~~in~~ He-P 4035.66(f) (parenteral)~~b)(1), and the experience required in 035.66(b)(2)~~.

## AND

**SECOND SECTION ~~– Complete for all submittals.~~**

☐ I attest that _____ has satisfactorily completed the ~~required~~ supervised clinical case
*Name of Proposed Authorized User*
experience (a minimum of 3 cases) required ~~in~~by He-P 4035.65(c)(2)b~~. listed below~~for the authorized use requested: *(Check all that apply)*

- ☐ Oral administration of less than or equal to 33 millicuries of sodium iodide I-131 for which a written directive is required
- ☐ Oral administration of greater than 33 millicuries of sodium iodide I-131
- ☐ Parenteral administration of any radioactive drug that contains a ~~beta emitter, or a photon emitting~~ radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation characteristics, ~~with a~~ or photon energy of less than 150 keV,~~ and/or parenteral administration of any other radionuclide,~~ for which a written directive is required

**AND**

**THIRD SECTION ~~– Complete for all submittals.~~**

☐ I attest that _____ has satisfactorily achieved a level of competency to function
*Name of Proposed Authorized User*

independently as an authorized user for the authorized use requested: *(Check all that apply)*

☐ Oral administration of less than or equal to 33 millicuries of sodium iodide I-131 for which a written directive is required

☐ Oral administration of greater than 33 millicuries of sodium iodide I-131

☐ Parenteral administration of any radioactive drug that contains a ~~beta emitter, or a photon emitting~~ radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation characteristics,~~with a~~ or photon energy less than 150 keV~~, and/or parenteral administration of any other radionuclide~~, for which a written directive is required

**FOURTH SECTION**

**~~Complete for 4035.66 (~~Current He-P 4035.59 or He-P 4035.69 Authorized User requesting Authorization for He-P 4035.66 (parenteral):**

☐ I attest that _____ is an authorized user under He-P 4035.59 or He-P 4035.69 or equivalent
*Name of Proposed Authorized User*

~~U.S. Nuclear Regulatory Commission~~ NRC or Agreement State requirements, has satisfactorily completed the training, experience and clinical cases ~~as~~ required by He-P 4035.66(~~g~~f)~~(4), and the experience required by 4035.66(g)(5)~~, and has achieved a level of competency sufficient to function independently as an authorized user for the He-P 4035.35 medical use stated below:

_____ **OR**

☐ I attest that _____ has satisfactorily completed the board certification requirements
*Name of Proposed Authorized User*

of He-P 4035.66(f) or equivalent NRC or Agreement State requirements, has satisfactorily completed the training, experience and clinical cases required by He-P 4035.66(f), and has achieved a level of competency sufficient to function independently as an authorized user for the He-P 4035.35 medical use stated below:

☐ Parenteral administration of any radioactive drug that contains a ~~beta emitter, or a photon emitting~~ radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation, ~~with a~~or photon energy or less than 150 keV for which a written directive is required

☐ Parenteral administration of any other radionuclide for which a written directive is required

**~~AND~~**

**~~Board Certification:~~**

☐ ~~I attest that _____ has satisfactorily completed the board certification~~
~~*Name of Proposed Authorized User*~~

~~requirements of 4035.66(g)(1), has satisfactorily completed the training required by 4035.66(g)(4) and the experience required by 4035.66(g)(5), and has achieved a level of competency sufficient to function independently as an authorized user for:~~

☐ ~~Parenteral administration of any beta emitter, or a photon emitting radionuclide with a photon energy less than 150 keV for which a written directive is required~~

☐ ~~Parenteral administration of any other radionuclide for which a written directive is required~~

**FIFTH SECTION** ~~— Complete for all submittals.~~

Authorized User

☐ I meet the requirements below~~,~~ or equivalent NRC~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements~~,~~ as an authorized user for the following:

☐ He-P 4035.65 ☐ He-P 4035.66(~~a~~<33 mCi I-131) ☐ He-P 4035.66(~~d~~>33 mCi I-131) ☐ He-P 4035.66(~~i~~Parenteral)

☐ I have experience administering dosages in the following categories for which the proposed authorized user is requesting authorization:

☐ Oral administration of less than or equal to 33 millicuries of sodium iodide I-131 for which a written directive is required

☐ Oral administration of greater than 33 millicuries of sodium iodide I-131

☐ Parenteral administration of any radioactive drug that contains a ~~beta emitter, or a photon emitting~~ radionuclide that is primarily used for its electron emission, beta radiation characteristics, alpha radiation characteristics, or~~with a~~ photon energy of less than 150 keV, ~~and/or parenteral administration of any other radionuclide,~~ for which a written directive is required

**OR**

Residency Program Director

☐ I affirm that the attestation represents the consensus of the residency program faculty where at least one faculty member is an authorized user who meets the following requirements or equivalent NRC or Agreement State requirements:

☐ He-P 4035.65 ☐ He-P 4035.66 (<33 mCi I-131) ☐ He-P 4035.66 (>33 mCi I-131) ☐ He-P 4035.66 (Parenteral)

☐ I affirm that this facility member concurs with the attestation I am providing as program director.

☐ I affirm that the residency training program is approved by the:

☐ Residency Review Committee of the Accreditation Council for Graduate Medical Education;

☐ Royal College of Physicians and Surgeons of Canada; or

☐ Council on Post-Graduate Training of the American Osteopathic Association.

☐ I affirm that the residency training program includes training and experience specified in:

☐ He-P 4035.65 ☐ He-P 4035.66 (<33 mCi I-131) ☐ He-P 4035.66 (>33 mCi I-131) ☐ He-P 4035.66 (Parenteral)

| **Name of Preceptor~~:~~** | **Signature~~:~~** | **Telephone Number~~:~~** | **Date~~:~~** |
|---|---|---|---|
| | | | |

~~**License/Permit Number/**~~**Facility Name~~**~~:~~** **License/Permit Number**

**FORM DHHS/RHS-1M**
Supplement C

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## AUTHORIZED MEDICAL PHYSICIST OR OPHTHALMIC PHYSICIST TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

***(New Hampshire Rules for the Control of Radiation He-P 4035.70 or He-P 4035.32)***

**Name of Proposed Authorized Medical Physicist:** _____ ☐ Authorized Medical Physicist

_____ ☐ Ophthalmic Physicist

**REQUESTED AUTHORIZED~~ATION~~ USE(S) -** ***Check all that apply:***

☐ He-P 4035.41~~67~~ Ophthalmic Use of Strontium-90 ☐ He-P 4035.47 Gamma Stereotactic Radiosurgery Unit(s)

☐ He-P 4035.47 Remote Afterloader Unit(s) ☐ He-P 4035.47 Teletherapy Unit(s)

## PART I – TRAINING AND EXPERIENCE

***(He-P 4035.32, He-P 4035.70, He-P 4035.71)***

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73. **For Ophthalmic Physicist**, skip to and complete page C4.

☐ **1. Board Certification for Proposed Authorized Medical Physicist**

a. Provide a copy of the board certification.

b. (i) If the board certification process has been recognized by the U.S. Nuclear Regulatory Commission (NRC) and meets the requirements of He-P 4035.70, then ~~U~~use the table in section 3.c. to describe training provider and dates of training for each type of use for which authorization is sought.

(ii) If board certification was on or before October 24, 2005 and is listed in He-P 4035.71(a)(3); provide documentation demonstrating the individual was using materials for the requested uses on or before October 24, 2005, and dates, duration and description of continuing education/experience within the previous 7 years for each use requested.

c. **STOP** here~~Skip to and complete Part II Preceptor Attestation~~.

**OR**

☐ **2. Current Authorized Medical Physicist Seeking Additional Authorization for Use(s) Checked Above**

a. Use the table in section 3.c. to document training for new device.

b. If not board certified, ~~S~~skip to and complete Part II Preceptor Attestation.

c. If board certified, provide a copy of the certificate and **STOP** here.

**OR**

☐ **3. Education, Training, and Experience for Proposed Authorized Medical Physicist**

a. Education: Document master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university.

Degree: _____

Major Field: _____

College or University: _____

b. Supervised Full-Time Medical Physics Training and Work Experience in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services, as required by He-P 4035.70(b)~~.~~:

☐ ~~Yes.~~ Completed 1 year of full-time training in medical physics (for areas identified below) under the supervision of _____ who meets the requirements for an Authorized Medical Physicist for the type(s) of use for which the individual is seeking authorization.

**AND**

☐ ~~Yes.~~ Completed an additional 1 year of full-time work experience in medical physics (for areas identified below) under the supervision of _____ who meets the requirements for an Authorized Medical Physicist for the type(s) of use for which the individual is seeking authorization..

**3. Education, Training, and Experience for Proposed Authorized Medical Physicist (continued)**

b. Supervised Full-Time Medical Physics Training and Work Experience (continued)
*(If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

| Description of Training/Experience | Location of Training License or Permit Number of Training Facility Medical Devices Used+ | Dates of Training*+ | Dates of Work Experience*+ |
|---|---|---|---|
| Medical physics | | | |
| Performing sealed source leak tests and inventories | | | |
| Performing decay corrections | | | |
| Performing full calibration and periodic spot checks of external beam treatment unit(s) | | | |
| Performing full calibration and periodic spot checks of stereotactic radiosurgery unit(s) | | | |
| Performing full calibration and periodic spot checks of remote afterloading unit(s) | | | |
| Conducting radiation surveys around external beam treatment ~~unit(s)~~, stereotactic radiosurgery ~~unit(s)~~, and/or remote afterloading unit(s) | | | |

**Supervising Individual****

**License/Permit Number listing supervising individual ~~as an Authorized Medical Physicist~~**

for the following types of use: ☐ ~~Ophthalmic use of strontium-90~~ ☐ ~~Remote afterloader unit(s)~~
☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

+ Training and work experience must be conducted in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services.

+* 1 year of full-time medical physics training and 1 year of full-time work experience **cannot be concurrent**.

** If the supervising medical physicist is not an authorized medical physicist, the licensee must submit evidence that the supervising medical physicist meets the training and experience requirements in He-P 4035.70 and 4035.73 for the types of use for which the individual is seeking authorization.

**3. Education, Training, and Experience for Proposed Authorized Medical Physicist (continued)**

c. Describe training provider and dates of training for each type of use for which authorization is sought.

| Description of Training | Training Provider and Dates | | |
|---|---|---|---|
| | Remote Afterloader | Teletherapy | Gamma Stereotactic Radiosurgery |
| Hands-on device operation | | | |
| Safety procedures for the device use | | | |
| Clinical use of the device | | | |
| Treatment planning system operation | | | |

**Supervising Individual**** ~~*If training was provided by Supervising Medical Physicist.*~~ *(If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

**License/Permit number listing supervising individual ~~as an authorized Medical Physicist:~~**

for the following types of use:

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

If applicable:

| Authorization Sought | Device | Training Provided By | Dates of Training |
|---|---|---|---|
| He-P 4035.~~67~~ 32 Ophthalmic use of ~~s~~Strontium-90 | | | |

d. Skip to and ~~C~~complete Part II Preceptor Attestation

# OPHTHALMIC PHYSICIST

## Education, Training and Experience for Proposed Ophthalmic Physicist

a. Education: Document master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university.

Degree: _____

Major Field: _____

College or University: _____

b. Supervised Full-Time practical training and work experience in Medical Physics, as required by He-P 4035.32(f):

☐ Completed 1 year of full-time training in medical physics at

_____

under the supervision of _____ Medical Physicist.

**AND**

☐ Completed an additional year of full-time work experience in medical physics at

_____

under the supervision of _____ Medical Physicist.

*(If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

c. Complete the table below to document training and supervised work experience.

| Description of Training | Location of Training<br>License or Permit Number of Training Facility | Dates of Training* |
|---|---|---|
| Creating, modifying and completing written directives. | | |
| Procedures for administrations requiring a written directive. | | |
| Performing the calibration measurements of brachytherapy sources as detailed in He-P 4035.46. | | |

| Supervising Individual | License/Permit number listing supervising individual |
|---|---|
| | |

a. **STOP** here.

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The authorized medical physicist preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one authorized medical physicist preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**FIRST SECTION** ~~– Check one of the following~~**:**

☐ ~~1. Board Certification~~

~~I attest that _____ has satisfactorily completed the requirements in~~
~~*Name of Proposed Authorized Medical Physicist*~~

~~He-P 4035.70(a), (b)(1) and (b)(2)a.; or 4035.70(a), (b)(1) and (b)(2)b.~~

~~**OR**~~

☐ ~~2. Education, Training, and Experience~~

I attest that _____ has satisfactorily completed the 1 year of full-time training
*Name of Proposed Authorized Medical Physicist*

and an additional year of full-time work experience in medical physics, as required by He-P 4035.70(b)~~(3) and (b)(4)~~.

**AND**

**SECOND SECTION**

☐ I attest that _____ has training for the types of use for which authorization
*Name of Proposed Authorized Medical Physicist*
is sought that includes hands-on device operation, safety procedures, clinical use and the operation of a treatment planning system.

**AND**

**THIRD**~~**SECOND**~~ **SECTION** ~~– Complete for all submittals.~~

☐ I attest that _____ is able to independently fulfill the radiation safety-related ~~has training for the types of use for which authorization~~
*Name of Proposed Authorized Medical Physicist*
duties~~is sought that includes hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system. Furthermore, this individual has achieved a level of competency sufficient to function~~ as an Authorized Medical Physicist for the following:

☐ He-P 4035.41 Ophthalmic Use of Strontium-90
☐ He-P 4035.47 Gamma Stereotactic Radiosurgery Unit(s)
☐ He-P 4035.47 Remote Afterloader Unit(s)
☐ He-P 4035.47 Teletherapy Unit(s)

**AND**

**FOURTH**~~**THIRD**~~ **SECTION** ~~– Complete for all submittals.~~

☐ I meet the requirements in He-P 4035.70, He-P 4035.71 or equivalent NRC ~~U.S. Nuclear Regulatory Commission~~ or Agreement State requirements, for an Authorized Medical Physicist for the following:

☐ He-P 4035.67 Ophthalmic Use of Strontium-90
☐ He-P 4035.59 Gamma Stereotactic Radiosurgery Unit(s)
☐ He-P 4035.59 Remote Afterloader Unit(s)
☐ He-P 4035.59 Teletherapy Unit(s)

| **Name of Preceptor~~:~~** | **Telephone Number~~:~~** |
|---|---|
| | |

| **Signature:** | **Date:** |
|---|---|
| **License/Permit Number / & Facility Name:** | |

**FORM DHHS/RHS-1M**
Supplement D

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## AUTHORIZED NUCLEAR PHARMACIST TRAINING, ~~AND~~ EXPERIENCE AND PRECEPTOR ATTESTATION

***(New Hampshire Rules for the Control of Radiation He-P 4035.74)***

| **Name of Proposed Authorized Nuclear Pharmacist~~:~~** | **State or Territory Where Licensed~~:~~** |
|---|---|
| | |

## PART I – TRAINING AND EXPERIENCE

***(He-P 4035.74, He-P 4135.71)***

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

a. Provide a copy of the board certification.

b. **STOP** here~~Skip to and complete Part II Preceptor Attestation~~.

**OR**

☐ **2. Structured Educational Program for Proposed Authorized Nuclear Pharmacist**

a. Classroom and Laboratory Training.

| Description of Training | Location of Training | Clock Hours | Dates of Training* |
|---|---|---|---|
| Radiation physics and instrumentation | | | |
| Radiation protection | | | |
| Mathematics pertaining to the use and measurement of radioactivity | | | |
| Chemistry of byproduct material for medical use | | | |
| Radiation biology | | | |

**Total Hours of Training~~:~~** _____

**2. Structured Educational Program for Proposed Authorized Nuclear Pharmacist (continued)**

b. Supervised Practical Experience in a Nuclear Pharmacy.

| Description of Experience | Location of Experience/ License or Permit Number of Facility | Clock Hours | Dates of Experience* |
|---|---|---|---|
| Shipping, receiving, and performing related radiation surveys | | | |
| Using and performing checks for proper operation of instruments used to determine the activity of dosages, survey meters, and, if appropriate, instruments used to measure alpha- or beta-emitting radionuclides | | | |
| Calculating, assaying, and safely preparing dosages for patients or human research subjects | | | |
| Using administrative controls to avoid medical events in administration of byproduct material | | | |
| Using procedures to prevent or minimize radioactive contamination and using proper decontamination procedures | | | |

**Total Hours of Experience~~:~~** _____

Supervising Individual~~:~~

c. Complete Part II Preceptor Attestation.

## PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**FIRST SECTION** ~~– Check one of the following:~~

☐ ~~1.~~ **~~Board Certification~~**

~~I attest that _____ has satisfactorily completed the requirements in~~
~~*Name of Proposed Authorized Nuclear Pharmacist*~~

~~He-P 4035.74(a) and (b)(1), (b)(2) and (b)(3) and has achieved a level of competency sufficient to function independently as an authorized nuclear pharmacist.~~

**~~OR~~**

☐ ~~2.~~ **Structured Educational Program for Proposed Authorized Nuclear Pharmacist**

I attest that _____ has satisfactorily completed a 700-hour structured ~~the training and experience~~
*Name of Proposed Authorized Nuclear Pharmacist*

educational program consisting of both practical experience in nuclear pharmacy and 200 hours of classroom and laboratory training, as required by He-P 4035.74(~~e~~b)(1) and has achieved a level of competency sufficient to function independently as an authorized nuclear pharmacist.

**AND**

**SECOND SECTION** ~~– Complete for all submittals.~~

I am an Authorized Nuclear Pharmacist for~~:~~ _____
*Name of Nuclear Pharmacy or Medical Facility*

License/Permit Number~~:~~ _____

| **Name of Preceptor~~:~~** | **Telephone Number~~:~~** |
|---|---|
| **Signature~~:~~** | **Date~~:~~** |

FORM DHHS/RHS-3

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## APPLICATION FOR RADIOACTIVE MATERIAL LICENSE–SOURCE MATERIAL

INSTRUCTIONS: Complete items 1 through 15 of this application. Use supplemental sheets where necessary. Item 15 shall be completed on all applications. Mail the original and one copy of the application package to: NH DHHS Radiological Health Section, Health and Welfare Building, Division of Public Health Services, NH Department of Health and Human Services, 29 Hazen Drive, Concord, New Hampshire 03301-6503. Upon approval of an application, the applicant shall receive a Radioactive Material License issued pursuant to statutory and implementing regulatory authority and subject to all applicable rules and orders of all appropriate regulatory agencies now or hereafter in effect and to any conditions specified in the license.

| | |
|---|---|
| 1a. NAME AND MAILING ADDRESS OF APPLICANT (institution, firm, clinic, physiciangovernment agency, etc.)<br><br>Tel. # ( ) _____-_____ Fax # ( ) _____-_____ | 1b. STREET ADDRESS(ES) WHEREAT WHICH SOURCE MATERIAL WILL BE USED/POSSESSED (if different from 1a) |
| 2. NAME OF PERSON TO CONTACT REGARDING THIS APPLICATION<br><br>Tel. # ( ) _____-_____<br>Email: | 3. THIS APPLICATION IS FOR (check appropriate item):<br>a. ☐ New license<br>b. ☐ Renewal of license no. _____ |
| 4. RADIATION SAFETY OFFICER (Name of person designated as radiation safety officer. Submit a If other than individual user, completed Form DHHS/RHS-1 Supplement A to document. Resumé stating training and experience optional.) | 5. INDIVIDUAL USERS (Name of individual(s) authorized to who will use or directly supervise use of source material. Submit a Ccompleted Form DHHS/RHS-1 Supplement A for each individual.) |

6. Describe purpose for which source material will be used.

7. State the type(s) or types, chemical form(s) or forms, and quantities of source material you propose to receive, possess, use, or transfer under the license.

| a. TYPE | b. CHEMICAL FORM | c. PHYSICAL FORM (including % U or Th) | d. MAXIMUM AMOUNT AT ANY ONE TIME (in pounds) |
|---|---|---|---|
| NORMAL URANIUM | | | |
| URANIUM DEPLETED IN THE U 235 ISOTOPE | | | |
| THORIUM | | | |

e. MAXIMUM **TOTAL QUANTITY** OF SOURCE MATERIAL YOU WILL HAVE ON HAND AT ANY ONE TIME (in pounds)

8. Describe the chemical, physical, metallurgical, or nuclear process or processes in which the source material will be used, indicating the maximum amount of source material involved in each process at any one time, and providing a thorough evaluation of the potential hazards associated with each step of those operations.

9. Describe the minimum technical qualifications, including training and experience, that will be required of applicant's supervisory personnel, including person responsible for radiation safety program (or of applicant if applicant is an individual).

10. Describe the equipment and facilities which will be used to protect health and minimize contamination ~~-~~of the environment and ~~danger to life or~~ property and relate the use of the equipment and facilities to the operations listed in Item 8.
    a. Radiation detection and related instruments including film badges, dosimeters, counters, air-monitoring or other survey equipment as appropriate. The description of radiation detection instruments should include the type of radiation detected and the range(s) of each instrument.
    b. Method, frequency, and standards used in calibrating instruments listed in a. above (for film badges, specify method of calibrating and processing or name of supplier).
    c. Ventilation equipment which will be used in operations which produce dust, fumes, mists, gases, etc.

11. Describe proposed procedures to protect health and minimize danger to life and property and relate these procedures to the operations listed in Item 8.
    a. Procedures for use of source materials and safety features and procedures to avoid non-nuclear accidents, such as fire, explosion, etc., in source material storage and processing areas.
    b. Emergency procedures in the event of accidents which might involve source material.
    c. Detailed description of radiation survey program and procedures.

12. Waste Products – Check appropriate item below.
    ☐ None will be generated.
    ☐ Waste products will be generated; explain the following on a supplemental sheet:
        a. Quantity and type of radioactive waste that will be generated (refer to Part He-P 4031.03 of the New Hampshire Rules for the Control of Radiation (NHRCR)).
        b. Detailed procedures for waste disposal.

13. If products for distribution to the general public, under an exemption contained in He-P 4030.02, NHRCR, ~~New Hampshire Radiological Health Section~~ are to be manufactured, use a supplement sheet to furnish a detailed description of the product including:
    a. Percent source material in the product and its location in the product.
    b. Physical description of the product including characteristics, if any, that will prevent inhalation or ingestion of source material that might be separated from the product.
    c. Beta and beta plus gamma levels (specify instrument used, date of calibration and calibration technique used) at the surface of the product and at 12 inches.
    d. Method of assuring that source material cannot be disassociated from the manufactured product.

14. SPECIFIC LICENSE FEE (Refer to Part He-P 4070, NHRCR~~New Hampshire Rules for the Control of Radiation.~~)

Category~~:~~ _____ Amount Enclosed~~:~~ $_____

15. CERTIFICATE (This item must be completed by applicant.)

I CERTIFY UNDER PENALTY OF LAW THAT THIS DOCUMENT AND ALL ATTACHMENTS WERE PREPARED IN CONFORMITY WITH THE NEW HAMPSHIRE RULES FOR THE CONTROL OF RADIATION UNDER MY DIRECTION OR SUPERVISION. THE INFORMATION SUBMITTED IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT THERE ARE SIGNIFICANT PENALTIES FOR SUBMITTING FALSE INFORMATION, INCLUDING THE POSSIBILITY OF FINE AND IMPRISONMENT FOR KNOWING VIOLATIONS.

_____
Signature of Authorized Signatory

_____
Name (type or print)

Date~~:~~ _____

_____
Title

# TRAINING AND EXPERIENCE

☐ AUTHORIZED USER ☐ RADIATION SAFETY OFFICER

## 1. NAME OF AUTHORIZED USER OR RADIATION OFFICER

## 2. FORMAL TRAINING IN RADIATION SAFETY

| Field of Training | Location and Date(s) of Training | Hours of Training | |
|---|---|---|---|
| | | Lecture/ Laboratory Courses | Supervised Laboratory Experience |
| Radiation Physics and Instrumentation | | | |
| Principles and Practices of Radiation Protection | | | |
| Mathematics Pertaining to the Use and Measurement of Radioactivity | | | |
| Biological Effects of Radiation | | | |

## 3. EXPERIENCE WITH RADIATION

(Actual use of Radioisotopes or Equivalent Experience)

| Isotope | Maximum Amount | Where Experience Was Gained | Duration of Experience | Type of Use |
|---|---|---|---|---|
| | | | | |

FORM DHHS/RHS-10

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## CERTIFICATE – DISPOSITION OF RADIOACTIVE MATERIAL ~~RADIOISOTOPES~~

| LICENSEE (Institution, firm, hospital, person, etc.) | LICENSE NUMBER |
|---|---|
| ADDRESS | |
| DEPARTMENT(S) | |

### CERTIFICATION

The licensee or any individual executing this certification on behalf of the licensee certify that (check appropriate item(s) below):

☐ A. No radioactive materials have been procured and/or possessed by the licensee.

☐ B. All radioactive materials (for termination) **OR**

☐ C. Specific radioactive materials (list below)

_____

_____

procured and/or possessed by licensee under Radioactive Material License No. _____

☐ (1) have been transferred to (state name of institution, firm, hospital, person, etc.)

_____

which has Radioactive Material License No. _____ issued by _____.

☐ (2) have been disposed of by decay.

☐ (3) have been disposed of in compliance with the provisions of He-P 4023, New Hampshire Rules for the Control of Radiation. Provide documentation of specific disposal procedures.

☐ (4) will not be used in the State of New Hampshire.

CERTIFICATE: I certify under penalty of law that this document and all attachments were prepared in conformity with the New Hampshire Rules for the Control of Radiation under my direction or supervision. The information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

_____
Signature of Authorized Signatory

Date~~:~~ _____

_____
Name and Title (type or print)

FORM DHHS/RHS-15

# STATE OF NEW HAMPSHIRE
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# RADIOLOGICAL HEALTH SECTION

## RADIOACTIVE MATERIAL RECIPROCITY APPLICATION


Radiological Health Section
Division of Public Health Services
NH Dept. of Health & Human Services
29 Hazen Drive, Concord, NH 03301
~~Health & Welfare Building~~
Phone No. (603) 271-4588
Fax No. (603) 225-2325


*This application must be received by the Agency at least 3 working days prior to engaging in an activity involving the use of radioactive material unless a waiver has been granted.*

**This is a ☐ New Application ☐ Revision**

| RECIPROCITY LICENSEE INFORMATION | WORK ACTIVITY LOCATION AND SCHEDULE |
|---|---|
| Licensee Name~~:~~ | Contact Person~~:~~ Phone No. |
| Mailing Address~~:~~ | Client Name~~:~~ |
| | Work Location Address~~:~~ City/Town~~:~~ |
| Radioactive Materials License No~~:~~ | |
| Issuing Agency~~:~~ | *Provide detailed description if remote location.* |
| Contact Person~~:~~ | Start Date~~:~~ Start Time~~:~~ |
| Phone No~~:~~ Fax No~~:~~ | End Date~~:~~ End Time~~:~~ |

**TYPE OF WORK TO BE PERFORMED**

☐ Portable Gauges ☐ Industrial Radiography ☐ Lead Paint Analysis
☐ Medical ☐ Leak Testing/Calibrations ☐ Source Exchange
☐ Other (describe)
Overnight Storage Needed: ☐ Yes ☐ No

**EQUIPMENT**

| Make | Model | Serial No. |
|---|---|---|
| | | |
| | | |
| | | |

**PERSONNEL** – Name of Person(s) Conducting Licensed Activities

1.
2.
3.
4.
5.

*Attach a separate page for additional personnel.*

**SOURCES**

| Source Serial No. | Isotope | Activity (Curies) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Additional Comments~~:~~**

***I hereby certify that all information provided in this application is true and complete, I have read and understand the provisions under He-P 4030.18, and I understand that activities, including storage, conducted in New Hampshire under this general license are limited to 180 days during any calendar year.***

**SIGNATURE~~:~~** **DATE~~:~~**

**NAME~~:~~** **TITLE~~:~~**