



**APPENDIX 2A - BOARD CERTIFIED PHYSICIAN
THERAPEUTIC RADIOPHARMACEUTICAL / RADIATION ONCOLOGY
APPENDIX 2A - PRECEPTOR ATTESTATION**

Name of Proposed Authorized User (Please Print)

Florida Medical License Number:

Requested Authorizations *check as applicable:*

- 64E-5.630(1) Use of Therapeutic Radiopharmaceuticals including parenteral use and sodium iodide I-131
- 64E-5.632 Use of Manual Brachytherapy
- 64E-5.634 Use of Sealed Sources in Remote Afterloader Units, Teletherapy Units, and Gamma Stereotactic Radiosurgery Units

PART I – TRAINING AND EXPERIENCE

Board certification, must have been obtained within the 7 years preceding the date of application.

Board Certification

Provide a copy of the specialty board certificate. Verify that the Certification Document meets the NRC certificate descriptions and limitations at: <http://www.nrc.gov/materials/miau/med-use-toolkit/spec-board-cert.html>

For authorized uses under 64E-5.632, Florida Administrative Code, (F.A.C.), proceed to Part II – Preceptor Attestation.

For authorized uses under 64E-5.630(1), F.A.C., provide documentation of supervised clinical case experience.

The table below may be used to document this experience. Then, proceed to Part II – Preceptor Attestation.

Description of Experience	Number of Cases Involving Personal Participation (minimum of 3)	Location of Experience and 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 beta-emitter, or photon-emitting radionuclide with a photon energy less than 150 keV for which a written directive is required			
Parenteral administration of any other radionuclide requiring a written directive: _____ (List radionuclide)			

Name of Supervising Individual (Please Print)

Signature

Date

Facility Name and License/Permit Number

Telephone Number

APPENDIX 2A

PART I -- TRAINING AND EXPERIENCE (continued)

For authorized uses under 64E-5.634, provide documentation of device operation, safety procedures and clinical use for the type(s) of use for which authorization is sought. The table below may be used to document this experience. Then proceed to Part II – Preceptor Attestation.

Vendor Name	Device Model Number and Isotope	Location of Experience and License or Permit Number of Facility	Dates of Training
Name of Supervising Individual (Please Print)		Signature	Telephone Number
			Date

PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the preceptor authorized user. The preceptor authorized user does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required.

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

Section A

Check the following for each requested authorization:

64E-5.630(1) Therapeutic Radiopharmaceuticals

I attest that the proposed authorized user has satisfactorily completed the requirements in 64E-5.660(1), F.A.C. and has achieved a level of competency to function independently as an authorized user for the medical uses authorized under 64E-5.630(1), F.A.C.

64E-5.632 Manual Brachytherapy

I attest that the proposed authorized user has satisfactorily completed the requirements in 64E-5.652(1), F.A.C. and has achieved a level of competency to function independently as an authorized user for the medical uses authorized under 64E-5.632, F.A.C.

64E-5.634 Remote Afterloader Units, Teletherapy Units, and Gamma Stereotactic Radiosurgery Units

I attest that the proposed authorized user has satisfactorily completed the requirements in 64E-5.655(1), F.A.C. and has achieved a level of competency to function independently as an authorized user for the medical uses authorized under 64E-5.634, F.A.C.

Section B

I am currently an authorized user under the following, or equivalent NRC or Agreement State authorizations:

64E-5.630(1), F.A.C.

64E-5.632, F.A.C.

64E-5.634, F.A.C.

Name of Preceptor (Please Print)

Signature

Date

Facility Name and License/Permit Number

Telephone Number