

**RPR 2E. MEDICAL USE TRAINING AND EXPERIENCE AND
PRECEPTOR ATTESTATION**

Part I – Training and Experience

1. Name, Proposed Authorization, Applicable Training Requirements

2. For Physicians, Podiatrists, Dentists, Pharmacists - State or Territory Where Licensed:

3. Certification - List applicable certifications and attach copies to this form.

Specialty Board	Category	Month/Year Certified

4. Current Authorizations - List any current authorizations and the license they are held under.

Authorization	License Number

5. Supervised Clinical Case Experience

Radionuclide	Type of Use	No. of Cases Involving Personal Participation	Name of Supervising Individual	Location and Corresponding Materials License Number	Dates and Number of Hours Experience

6. Training For Sections: 35.51(c) (AMP), 35.590(c) (Sealed Diagnostic Sources), or 35.690(c) (Remote Afterloader, Teletherapy, and Gamma Sterotactic Units)

Training Element	Type of Training *	Location and Date

*Types of training may include supervised, didactic, or vendor training.

7. Formal Training – For physicians and medical physicists performing manual brachytherapy or using remote afterloader, teletherapy, or gamma stereotactic units under 35.400 or 35.600.

Degree, Area of Study, or Residency Program	Name and Location of Program with Materials License Number	Dates	Organization Approving Program and Applicable Regulation

8. Medical Physicist – One-Year Full-Time Training/Work Experience

Yes Completed 1 year of full-time training in therapeutic radiological physics (35.961) or medical physics (35.51) under the supervision of

N/A _____ who is a medical physicist (35.961) or meets the requirements for Authorized Medical Physicists (35.51);

AND

Yes Completed 1 year of full-time work experience for (specify unit or device) _____ under the supervision of

N/A _____ who is a medical physicist (35.961) or meet requirements for Authorized Medical Physicists on (specify use or device) _____.

Applicant Name	Applicant Signature	Date
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9. Supervising Individual – Identification and Qualifications

The training and experience indicated above was obtained under the supervision of :

A. Name of Supervisor: _____.

B. Supervisor Authorized User Authorized Nuclear Pharmacist
 is: Radiation Safety Officer Authorized Medical Physicist

C. Supervisor meets requirements of 10 CFR Part 35 Section(s) _____
 for medical uses in Part 35, Section(s) _____.

D. Address	E. Materials License Number.
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Part II – Preceptor Attestation

Note: This part must be completed by the applicant’s preceptor. If more than one preceptor is necessary to document experience, obtain separate preceptor statements from each.

I attest that the individual named in item 1:

11a. has satisfactorily completed the requirements in Part 35, Section(s) and Paragraph(s) _____, as documented in section(s) _____ of this form.

11b. meets the requirements in 35.51(c) 35.390(b)(1)(ii)(G) 35.690(c) for types of use, as documented in section(s) _____ of this form.
 N/A

11c. has achieved a level competency sufficient to independently operate a nuclear pharmacy (for 35.980); **OR**
 has achieved a level of competency sufficient to function independently as an authorized _____ for _____ uses (or units); **OR**
 N/A

11d. I am an Authorized Nuclear Pharmacist; **OR** I am a Radiation Safety Officer; **OR**
 I meet the requirements of _____ section(s) of 10 CFR Part 35 or equivalent Agreement State requirements to be a preceptor AU or AMP for the following byproduct material uses (or units): _____.

A. Address	B Materials License Number
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C. Name of Preceptor	D. Signature – Preceptor	E. Date
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