



**INITIAL APPLICATION FOR  
MEDICAL PHYSICIST REGISTRATION**

39.3(3) of the Iowa Radiation Machines and Radioactive Materials Rules requires registration of each person who is engaged in the business of installing or offering to install radiation machines or is engaged in the business of furnishing or offering to furnish radiation machine servicing or services in Iowa. This includes radiation protection or health physics consultations or surveys. **Each medical physicist must be registered individually.**

Please submit this application and any supporting documentation required below to the IDPH along with the appropriate fee. Call (515)380-8837 for therapy or (515)281-0405 for mammography if you have questions.

\_\_\_\_\_  
Name of the medical physicist (print or type)

\_\_\_\_\_  
Business Name

\_\_\_\_\_  
Business address, city, state, and zip code

\_\_\_\_\_  
Business e-mail address

\_\_\_\_\_  
Business phone number

\_\_\_\_\_  
Business fax

**1. Radiation Therapy Physicist**

**PLEASE CHECK THE APPROPRIATE BOX(S) (AT LEAST ONE) AND PROVIDE THE SUPPORTING DOCUMENTATION.**

- Currently certified by the American Board of Radiology in:
- Therapeutic radiological physics
  - Roentgen-ray and gamma-ray physics
  - X-ray and radium physics
  - Radiological physics
- Currently certified by the American Board of Medical Physics in radiation oncology physics
- Currently certified by the Canadian College of Physicists in Medicine
- Request to qualify under 641-41.3(6)"e"
- a. hold a master's or doctor's degree in physics, biophysics, radiological physics, or health physics;
  - b. have completed one year of full-time training in therapeutic radiological physics;
  - c. and have one year full-time work experience under the supervision of a radiation therapy physicist at a medical institution.
- All experience shall have been performed under the supervision of a radiation therapy physicist already meeting these requirements.

**Submit documentation to verify all your answers.**

## 2. Mammography Medical Physicist

**PLEASE CHECK THE APPROPRIATE BOX(ES) AND PROVIDE THE SUPPORTING DOCUMENTATION. COMPLETE ONE SECTION ONLY (A-C).**

ABR Certification  Yes  No Area of Certification: \_\_\_\_\_

### 2A:

please check

Yes  No I have a Ph.D. in a physical science.

*If answered no, please go to the Section B.*

*If answered yes, complete the following questions in this section.*

Yes  No I have at least 20 hours of college level physics

Yes  No I have at least 20 contact hours of documented specialized training in conducting surveys of mammography facilities.

Yes  No I have the experience of conducting surveys of at least one (1) mammography facility and a total of at least 10 mammography units.

I have the following Continuing Education and Experience:

Yes  No 15 Continuing Education Units in the past 36 months.

Yes  No Surveyed two (2) mammography facilities in the past 24 months.

Yes  No Surveyed six (6) mammography units in the past 24 months.

### 2B:

please check

Yes  No I have a Masters Degree in a physical science.

*If answered no, please go to the Section C.*

*If answered yes, complete the following questions in this section.*

Yes  No I have at least 20 hours of college level physics

Yes  No I have at least 20 contact hours of documented specialized training in conducting surveys of mammography facilities.

Yes  No I have the experience of conducting surveys of at least one (1) mammography facility and a total of at least 10 mammography units.

I have the following Continuing Education and Experience:

Yes  No 15 Continuing Education Units in the past 36 months.

Yes  No Surveyed two (2) mammography facilities in the past 24 months.

Yes  No Surveyed six (6) mammography units in the past 24 months.

### 2C:

please check

Yes  No I have a Bachelor's Degree in a physical science

*If answered yes, complete the following questions in this section.*

Yes  No I have at least 10 hours of college level physics

Yes  No I have at least 40 contact hours of documented specialized training in conducting surveys of mammography facilities.

Yes  No I have the experience of conducting surveys of at least one (1) mammography facility and a total of at least 20 mammography units.

I have the following Continuing Education and Experience:

Yes  No 15 Continuing Education Units in the past 36 months.

Yes  No Surveyed two (2) mammography facilities in the past 24 months.

Yes  No Surveyed six (6) mammography units in the past 24 months.

**Submit documentation to verify all your answers.**

### 3. Stereotactically Guided Breast Biopsy Medical Physicist

PLEASE CHECK THE APPROPRIATE BOX(ES) AND PROVIDE THE SUPPORTING DOCUMENTATION. COMPLETE ONE SECTION ONLY (A OR B)

Yes  No I meet the initial requirements for a Mammography Medical Physicist in section 2.

#### 3A:

please check

Yes  No Prior to July 1, 1998, have performed three hands-on Stereotactic breast biopsy physics surveys

I have the following Continuing Education and Experience:

Yes  No 3 Continuing Education Units in the past 36 months.

Yes  No Surveyed 1 stereotactic unit in the past 12 months.

#### 3B:

please check

Yes  No Have performed one hands-on Stereotactic breast biopsy physics survey under the guidance of a qualified medical physicist.

I have the following Continuing Education and Experience:

Yes  No 3 Continuing Education Units in the past 36 months.

Yes  No Surveyed 1 stereotactic unit in the past 12 months.

**Submit documentation to verify all your answers.**

#### FEES:

Section 1                      Radiation therapy physicist                      \$200                      \_\_\_\_\_

Section 2 and/or 3                      Mammography and/or stereotactically-guided breast biopsy physicist                      \$100                      \_\_\_\_\_

Total fee in a check or money order made payable to the IDPH                      \_\_\_\_\_

Social Security number: \_\_\_\_\_

Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

1. Do you have a medical condition, which in any way currently impairs or limits your ability to perform the duties of this profession? Medical Condition: means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.  Yes  No

*If yes, provide a description of your condition and submit a letter from a physician stating how your condition will affect your ability to perform the duties of this profession.*

2. Have you, within the past 5 years, engaged in the illegal or improper use of drugs or other chemical substances?  Yes  No  
*If yes, provide a statement and a copy of relevant documentation including records from a physician or treatment program.*
3. Have you ever been convicted of a misdemeanor or felony crime? (You do not need to answer yes if your sole conviction or convictions are for minor traffic violations with fines under \$250). In answering this question, note that a conviction means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. This means you must answer yes if a finding or verdict of guilt was returned against you in a criminal proceeding or if you plead guilty, entered a plea of nolo contendere, or entered an Alford plea in a criminal proceeding, even if the court expunged the matter or the court deferred judgment. You must submit the complaint and judgment of conviction for each offense.  Yes  No  
*If yes, include the date, location, charging orders, court disposition, and current status (i.e. probation) for each charge.*
4. Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you?  Yes  No  
*If yes, include the date, location, reason, and resolution.*
5. Have there ever been judgments or settlements paid on your behalf as a result of a professional liability case?  Yes  No  
*If yes, include the date, location, reason, and resolution.*
6. Have you ever had a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body?  Yes  No  
*If yes, provide a description of the circumstances.*

I understand this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. I have read and understand the requirements of the Iowa Rules. The information provided in this application is true to the best of my knowledge. I will notify the IDPH immediately of any changes in this application. I understand that providing false documents in this application will result in revocation of this authorization for medical physicist services. Once approved, I will not perform services that are not specifically stated in this application or on the notice of registration that will be issued by the IDPH until given permission in writing by the IDPH.

**Please return this application, any supporting documentation and the appropriate fee to the IDPH.**

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date