**MARYLAND BOARD OF PHYSICIANS**
**Allied Health Division**
**4201 Patterson Avenue**
**Baltimore, MD 21215**
**410-764-4777; 1-800-492-6836**
**www.mbp.state.md.us**

# APPLICATION FOR APPROVAL TO OPERATE A CT/NUCLEAR MEDICINE DEVICE FOR NON-DIAGNOSTIC ATTENTUATION CORRECTION WITHOUT INTRAVENOUS CONTRAST

**This application is for nuclear medicine technologists who have met certain criteria and want to operate a non-diagnostic CT/Nuclear Medicine device without contrast.**

**Requirements:**

1. Current Maryland licensure as a nuclear medicine technologist.
2. Documentation of completion of a cross sectional anatomy class which was part of an accredited nuclear medicine technology educational program* or consisted of at least 3 continuing education credit hours; and
3. Documentation of having performed the following CT exams in the presence of a qualified CT and/or a physician.
    - 10 routine head,
    - 20 chests;
    - 10 abdomens; and
    - 10 additional studies of the abdomen or portions of the abdomen.

**Approval:**

If the nuclear medicine technologist meets the criteria, Board staff will issue an approval letter.

**Operation of a Free-standing CT:**

Approval does not permit a Nuclear Medicine Technologist to operate a free-standing CT.

**Mailing Instructions:**

Applications should be mailed to the Board using the address on the top of the application.

**Important:**

Retain a copy of the documentation you submitted to the Board for your personal record.

**Glossary:**

"Qualified CT technologist" means a Maryland licensed medical radiation technologist (MRT) who has been certified by the ARRT in CT or has at least five years experience operating a CT.

"Physician" means a Maryland licensed radiologist or a physician who is proficient in operating CT equipment.

*An accredited nuclear medicine technology educational program means an educational program which is accredited by the Joint Review Committee on Education in Radiologic Technology (JRCERT) or the Joint Review Committee on Educational Programs in Nuclear Medicine Technology.

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# VERIFICATION OF CROSS SECTIONAL ANATOMY CLASS FOR OPERATION OF A CT/NUCLEAR DEVICE FOR NON-DIAGNOSTIC ATTENUATION CORRECTION CT WITHOUT INTRAVENOUS CONTRAST

**APPLICANT**: Please complete **Part 1** and send to the school/program from which you completed the cross sectional anatomy class. **Print or type all information**.

**PART 1**:

Name: _____
Last First Middle Maiden Name

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Name of Approved School: _____

Inclusive Dates of Attendance: From: _____ to _____
mm/yyyy mm/yyyy

Signature of Applicant_____ Date _____

**********

**TO BE COMPLETED BY AUTHORIZED OFFICIAL**: Please complete **Part 2** and mail the entire form directly to the Maryland Board of Physicians at the above address.

**PART 2:**

I hereby certify that the above-named individual completed a cross sectional anatomy class on: _____.
Date of Completion

The inclusive dates of attendance were _____ to _____. The class was part of an approved school's

curriculum and accredited by _____.
Name of accreditor, e.g. JRCERT

_____
Name of School Program

_____
Name and Title of School Official (Print)

_____ _____
Signature of School Official Date

_____ **SEAL OF THE EDUCATIONAL INSTITUTE**
Telephone Number Including Area Code

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# VERIFICATION OF CONTINUING EDUCATION
# OPERATION OF A CT/NUCLEAR DEVICE FOR NON-DIAGNOSTIC ATTENUATION CORRECTION CT WITHOUT INTRAVENOUS CONTRAST

**Applicant:** Please complete the form and attach documentation of three hours of continuing education in lieu of completing the cross sectional anatomy class.

Maryland license number: _____

Name: _____
Last First Middle Maiden

1. a. Name of CT Imaging Course #1: _____

   b. ASRT/VOICE Program Number: _____

   c. Instructor: _____

   d. Date of course: _____

2. a. Name of CT Imaging Course #2: _____

   b. ASRT/VOICE Program Number: _____

   c. Instructor: _____

   d. Date of course: _____

3. a. Name of CT Imaging Course #1: _____

   b. ASRT/VOICE Program Number: _____

   c. Instructor: _____

   d. Date of course: _____

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# VERIFICATION OF CT PROCEDURES WITHOUT CONTRAST

**Instructions:** Complete each section of the form. The NMT must perform each of the following procedures in the presence of a qualified CT technologist and/or a physician**: 10 routine heads, 20 chests, 10 abdomens; and 10 additional studies of the abdomen or portions of the abdomen for a total of 50 procedures.** The CT Technologist and/or the physician must initial each observed procedure and then sign the form attesting that he/she observed the NMT performing the CT procedures.

Name of NMT: _____ Maryland License Number: _____

| Type of Procedure | Procedure Number | Date/time Performed | Facility Name | Patient Identifier | Verified by: (initials) | Maryland License # |
|---|---|---|---|---|---|---|
| *Head* | | | | | | |
| | 1 | | | | | |
| | 2 | | | | | |
| | 3 | | | | | |
| | 4 | | | | | |
| | 5 | | | | | |
| | 6 | | | | | |
| | 7 | | | | | |
| | 8 | | | | | |
| | 9 | | | | | |
| | 10 | | | | | |

Name of NMT: _____ Maryland License Number: _____

| Type of Procedure | Procedure Number | Date/time Performed | Facility Name | Patient Identifier | Verified by: (initials) | Maryland License # |
|---|---|---|---|---|---|---|
| *Chest* | | | | | | |
| | 1 | | | | | |
| | 2 | | | | | |
| | 3 | | | | | |
| | 4 | | | | | |
| | 5 | | | | | |
| | 6 | | | | | |
| | 7 | | | | | |
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| | 15 | | | | | |
| | 16 | | | | | |
| | 17 | | | | | |
| | 18 | | | | | |
| | 19 | | | | | |
| | 20 | | | | | |

Name of NMT: _____ Maryland License Number: _____

| Type of Procedure | Procedure Number | Date/time Performed | Facility Name | Patient Identifier | Verified by: (initials) | Maryland License # |
|---|---|---|---|---|---|---|
| *Abdomens* | | | | | | |
| | 1 | | | | | |
| | 2 | | | | | |
| | 3 | | | | | |
| | 4 | | | | | |
| | 5 | | | | | |
| | 6 | | | | | |
| | 7 | | | | | |
| | 8 | | | | | |
| | 9 | | | | | |
| | 10 | | | | | |
| | | | | | | |
| *Abdomen: 10 additional studies or portions* | | | | | | |
| | 1 | | | | | |
| | 2 | | | | | |
| | 3 | | | | | |
| | 4 | | | | | |
| | 5 | | | | | |
| | 6 | | | | | |

Name of NMT: _____ Maryland License Number: _____

| **Type of Procedure** | **Procedure Number** | **Date/time Performed** | **Facility Name** | **Patient Identifier** | **Verified by: (initials)** | **Maryland License #** |
|---|---|---|---|---|---|---|
| *Abdomen: 10 additional studies or portions (continued)* | | | | | | |
| | 7 | | | | | |
| | 8 | | | | | |
| | 9 | | | | | |
| | 10 | | | | | |
| | | | | | | |
| **Total =** | **50** | | | | | |
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# ATTESTATION OF COMPLETION OF CT PROCEDURES ON A CT/NUCLEAR MEDICINE DEVICE FOR NON-DIAGNOSTIC ATTENTUATION CORRECTION WITHOUT INTRAVENOUS CONTRAST BY A NUCLEAR MEDICINE TECHNOLOGIST

The following attestations must be signed and dated by the NMT, qualified CT technologist and the Medical Director of the Imaging Department to verify completion of the following CT examinations: 10 routine head, 20 chests, 10 abdomens, and 10 additional studies of the abdomen or portions of the abdomen.

**Nuclear Medicine Technologist**: I attest that I successfully have completed the required number of CT exams.

_____ _____
Nuclear Medicine Technologist's Signature/MD License# Date

**CT Technologist**: I attest that _____ performed at the required CT exams
Name of NMT
in my presence.

I also attest that: (Check one)

_____ I have at least five years experience operating a CT; or

_____ I am certified by the ARRT in CT. My ARRT number is _____.

_____ _____
Supervising R.T.(R)'s Name in Print/MD License # Date

_____
Supervising R.T.(R)'s Signature

**Medical Director**: I have reviewed the *Verification of CT Procedures form* for completeness.

_____ _____
Medical Director's Name in Print/ MD License # Date

_____
Medical Director's Signature

We also attest that the information given in this record is true and correct, and that we have read and understand the Statue and Regulations which govern Radiation Therapy, Radiography, and Nuclear Medicine Technology in the State of Maryland - Health Occupations Article Section 14-5B, et. seq and COMAR 10.32.10. We also understand that any false information provided as a part of this record may be cause for disciplinary action.

_____ _____ _____
NMT's Signature CT 's Signature Medical Director's Signature