OFFICE USE ONLY

Name:..... A/C # .....

AUSTRALIAN AND NEW ZEALAND SOCIETY OF NUCLEAR MEDICINE

ABN 35 133 630 029

APPLICATION
TECHNOLOGIST ACCREDITATION IN NUCLEAR MEDICINE

Before completing this application, please note the following:

1. All four feedback forms should have been completed and sent to Mentor.

2. Completed application form is to be forwarded to:

   Robyn Smith
   ANZSNM
   PO Box 202
   PARKVILLE VIC. 3052

   Fax: 61 (0) 3 93879627
   Email: secretariat@anzsnm.org.au

3. The application form is in three (3) sections to be completed as follows: (Should space be insufficient in any section, please attach additional pages)

   i **Section 1**
   To be completed by the applicant

   ii **Section 2**
   To be completed by:
   The Nuclear Medicine Technologist-in-Charge and
   The Nuclear Medicine Physician-in-Charge

   iii **Section 3**
   ANZSNM Board use **only**

4. A **notarized** copy of your award (verified as a true copy of the original document by a physician or justice of the peace) **MUST** be provided unless sent with PDY application (see page 5 of this form).

Section 1

PART A : PERSONAL INFORMATION

Surname: ……. Given Names: …… Date of

Birth: ……..

Contact number: ……. Email: .....

Private address: ……

State:…… Postcode:……

Postal address (address to which your Accreditation certificate will be mailed):

……

State:…… Postcode:……

PART B: WORKPLACE INFORMATION

ALL FOUR FEEDBACK FORMS MUST HAVE BEEN FORWARDED TO YOUR MENTOR (IN VICTORIA, TO YOUR NMIC MENTOR)
PRIOR TO SUBMITTING THIS APPLICATION TO THE ANZSNM SECRETARIAT

PART C: ACADEMIC QUALIFICATION(S) IN NUCLEAR MEDICINE

University: …… Degree (or equivalent No.) …….. Year of Graduation

……..

Other relevant qualifications: ……

……

PART D: ACADEMIC QUALIFICATION(S) OTHER THAN NUCLEAR MEDICINE

Please attach any relevant documentation Yes / No / Not applicable

Signature of applicant: …… Date: ……

Section 2

What approved course in Nuclear Medicine has the applicant completed? ……

…….. Employment start date:

.....

PDY or Internship start date: ..... (if different to above. You will have been notified of a different start date by the Board if your application was received more than 30 days after commencement of employment.)

Has the applicant now completed one full calendar year of full-time practice in an approved department? (A minimum of 48 weeks full-time equivalent workplace experience is required, commencing on the official PDY start date. Annual leave and weeks of sick leave may not be counted.)

YES NO

Has the applicant been absent from the workplace for any extensive period of time (other than annual leave and certified sick leave)? Rotations to other hospitals or centralised radiopharmacy laboratories should be listed – please provide details.)

YES NO

If yes, provide details: ……

…….. Do you recommend the

applicant for accreditation? YES NO

Nuclear Medicine Technologist in charge: ……

(PRINT NAME)

Signature: …… Date: ……..

Nuclear Medicine Physician in Charge: ……..

(PRINT NAME)

Signature: …….. Date: ……

Section 2 continued

Has the applicant completed the following? Please indicate whether these were covered and whether Onsite or Off- site. Please circle responses.

CPR/Basic Life Support Training	Yes	No	Onsite	Offsite
Hospital/Department Safety Procedures	Yes	No	Onsite	Offsite
Manual Handling Instruction	Yes	No	Onsite	Offsite
Venipuncture & IV cannulation	Yes	No	Onsite	Offsite
Minimum of 6 weeks Hot Laboratory	Yes	No	Onsite	Offsite
Radiopharmacy Quality control	Yes	No		
Radionuclide Administration	Yes	No		
(IV, Oral & Inhalation) Radionuclide Therapy	Yes	No	Onsite	Offsite

Please list therapeutic procedures:

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.. Practical Experience in Cell Labelling	Yes	No	Onsite	Offsite
	White Cell		Red Cell	Variations of both
4 weeks exposure to Paediatrics	Yes	No	Onsite	Offsite
PET or CoPet studies	Yes	No	Onsite	Offsite
Wide range of Scintigraphic Procedures	Yes	No		
Cardiac Nuclear Medicine	Yes	No		
Tracer studies/Cold Laboratory	Yes	No	Onsite	Offsite

Please list:

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Radiation Protection	Yes	No		
Nuclear Medicine Instrumentation & QC	Yes	No		
Exposure to Allied Health Fields	Yes	No	Onsite	Offsite

Please list:

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Has the applicant developed suitable Patient Care and Interpersonal skills? Yes No

Please describe involvement in Professional Development Activities:

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Section 3
ANZSNM BOARD USE ONLY

DATE RECEIVED:

PRACTICAL EXPERIENCE VERIFIED BY PHYSICIAN IN CHARGE:

APPROVED COURSE COMPLETED: _____

NOTARISED COPY OF CERTIFICATE SUPPLIED: _____

If you provided a notarised copy of your degree with your PDY/Mentor Program application, this will be noted above. If not indicated above, you MUST supply a notarised copy of your degree with this form, otherwise your application for Accreditation cannot be finalised.