PET Clinical Hours & Competencies Verification Form

The Nuclear Medicine Technology Certification Board

Section I. Applicant Information (*To be completed by applicant)*

Applicant Name: _____ **NMTCB Certification Number**: _____

Other Organization(s) Certification Number: _____

Mailing Address: _____ **Primary Phone:** _____

_____ **Primary E-mail**: _____

Section II. Authorized Representative Review and Verification

This section must be completed by applicant's Supervising Physician ***AND*** Technical Supervisor, or Certified Nuclear Medicine Technologist either CNMT, ARRT (N), or CAMRT (RTNM) credentialed employee of the facility. Only authorized representatives of the facility may attest to this verification of the applicant's competencies.

Clinical hours and procedures must be obtained within 5 years of application for the PET exam. Clinical procedures may be performed on one type of scanner, or a combination of multiple scanners. PET clinical hours and procedures may only be obtained with an Active CAMRT(RT), CAMRT(RTT), ARRT(R) or ARRT(T) certification AND hold an active certification in Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) from a nationally recognized certification board.

The **Applicant** named above has applied for admission to the Nuclear Medicine Technology Certification Board's PET Examination. As part of the NMTCB's pre-examination qualifying procedure, we require written confirmation of the candidate's clinical history in PET. You can assist us in this process by completing and returning this form to us as soon as possible. The applicant has signed a release authorizing the NMTCB to confirm the information contained in his/her application and has authorized the NMTCB to request information related to their education, employment, relevant personal history, and professional license, registration, and certification.

Please complete the following questions:

1. Did the applicant complete a minimum of **1,000** total clinical hours in PET, PET/CT, and/or PET/MR at your institution?

   YES____ or **NO** _____, the applicant completed _____ clinical hours, during the time period of ___/___/___ to ___/___/___);

2. Has the applicant's clinical hours and competencies been obtained within the past five (5) years? **YES**____ or **NO** ____

3. What type of scanner were the applicant's clinical hours performed on at your institution? *(please select one)*

   ☐ **PET/CT** ☐ **PET/MR** ☐ **PET** ☐ **A combination of multiple scanners**

4. Complete the **PET Clinical Hours and Competencies Verification (Excel Document)** and include the totals below:

   a) Any PET imaging performed: _____ (Minimum of **50** Required)
   b) Daily QC performed: _____ (Minimum of **10** Required)
   c) Dose Calibrator QC performed: _____ (Minimum of **10** Required)
   d) Daily Survey & Survey Meter QC: _____(Minimum. of **10** Required)
   e) Package Receipt, Disposal, & Return: _____ (Minimum. of **10** Required)
   f) Radiopharmaceutical Preparation, includes dose calculation & dose assay: _____ (Minimum of **10** Required)

Positron Emission Tomography (PET) Clinical Competency Verification Form

Competency Requirements:

Applicants must document a minimum of 100 prescribed competencies as follows: 50 in any PET imaging; 10 Daily Scanner Quality Control; 10 Dose Calibrator Quality Control; 10 Daily Survey & Survey Meter Quality Control; 10 package receipt, disposal, and return; 10 radiopharmaceutical preparation, including dose calculation and dose assay. **No more than one (1) competency may be documented per day per category**. Supervision must be performed by a nuclear medicine physician or radiologist (must be authorized user on the radioactive material license for diagnostic radiopharmaceuticals) ***and*** direct supervision must be performed by a certified NMTCB, ARRT(N), or CAMRT(RTNM) nuclear medicine technologist.

In order for a procedure to qualify, they must be performed independently from the start to finish. Each procedure should include patient assessment and preparation, radiopharmaceutical handling (if permitted by state and/or institutional regulations), injection (if permitted by state and/or institutional regulations), patient positioning, protocol and parameter selection, post-processing and Quality Control.

***Instructions*:**
Complete NMTCB PET Procedure Verification Excel Form – First Excel Tab and then include the competency totals on page 1 of this form.

Authorized Representative Attestation

*The applicant's Supervising Physician (nuclear medicine physician or radiologist that is an authorized user listed on a radioactive material license) **and** Technical Supervisor whom is a Certified Nuclear Medicine Technologist either CNMT, ARRT (N), or CAMRT (RTNM) credentialed employee of the facility.*

Supervising Physician #1

I attest that the information contained herein is true and accurate. I am an authorized representative and may sign this verification submission on behalf of the following institution: _____
(Name of Institution/Facility)

_____ _____
Signature of Authorized Representative **Date Signed**

_____ _____
Printed Name of Authorized Representative **Telephone**

_____ _____
Title **Email**

Supervising Physician #2 (if applicable)

I attest that the information contained herein is true and accurate. I am an authorized representative and may sign this verification submission on behalf of the following institution: _____
(Name of Institution/Facility)

_____ _____
Signature of Authorized Representative **Date Signed**

_____ _____
Printed Name of Authorized Representative **Telephone**

_____ _____
Title **Email**

Supervising Technologist #1

I attest that the information contained herein is true and accurate. I am an authorized representative and may sign this verification submission on behalf of the following institution: _____

(Name of Institution/Facility)

_____ _____

Signature of Authorized Representative **Date Signed**

_____ _____

Printed Name of Authorized Representative **Telephone**

_____ _____

Title **Email**

Supervising Technologist #2 (if applicable)

I attest that the information contained herein is true and accurate. I am an authorized representative and may sign this verification submission on behalf of the following institution: _____

(Name of Institution/Facility)

_____ _____

Signature of Authorized Representative **Date Signed**

_____ _____

Printed Name of Authorized Representative **Telephone**

_____ _____

Title **Email**

Return completed form to NMTCB by mail, fax, or email:

NMTCB – Examinations Manager
3558 Habersham at Northlake, Building I
Tucker, GA 30084
Fax: (404) 315-6502 **Email:** exam.manager@nmtcb.org

Please confirm all three (3) pages and your excel document are included in your transmission.