CT 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 Program Director, Clinical Coordinator, Supervising Physician, Technical Supervisor, or an NMTCB(CT) or ARRT(CT) credentialed employee of the facility who witnessed the applicant performing the procedure. Only authorized representatives of the facility may attest to the verification of the applicant's competencies.

Clinical hours and competencies must be obtained within 3 years of application for the CT exam. Clinical competencies may be performed on one type of scanner, or a combination of multiple scanners. Clinical hours and competencies may be obtained prior to being certified as a nuclear medicine technologist and confirmed by the Program Director, Technical Supervisor, or Supervising Physician.

Hours completed in an NMT Educational Program must be verified by the Program Director or Clinical Coordinator. Clinical hours and competencies can be obtained in the role of a student in an accredited nuclear medicine program prior to certification. If the applicant will not complete all requirements prior to graduation, the NMT Educator may notate the hours/competencies that were obtained and give the completed form to graduating student.

The **Applicant** named above has applied for admission to the Nuclear Medicine Technology Certification Board's CT Examination. As part of the NMTCB's pre-examination qualifying procedure, we require written confirmation of the candidate's clinical history in computed tomography. 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, professional license, registration, and certification.

Please complete the following questions:

1. Did the applicant complete a minimum of **300** total clinical hours in PET/CT, SPECT/CT and/or CT at your institution?

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

2. Has the applicant's clinical hours been obtained within the past three (3) 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** ☐ **SPECT/CT** ☐ **Stand-alone CT** ☐ **A combination of multiple scanners**

4. Please complete the **CT Clinical Competency Verification Form** on Pages (**2-5**) of this document.

Computed Tomography (CT) Clinical Competency Verification Form

Procedural Requirements:

Applicants must perform at least **10** of the different procedures listed below (at a minimum of 3 times and a maximum of 5 times each) for a total of at least **50** repetitions. The use of intravenous (I.V.) contrast is required for **25** of the 50 procedures performed by the applicant. Applicants may only document one procedure per patient *per* study.

In order for a procedure to qualify, the parameters selected for the procedure should be considered diagnostic quality and not performed for attenuation correction only. Each procedure should include patient assessment and preparation, patient positioning, protocol and parameter selection, post-processing and Quality Control, if permitted by state and/or institutional regulations. The applicant must demonstrate competency in Quality Assurance, including calibration checks, CT number, and standard deviation (water phantom).

Procedures may be performed in conjunction with a PET or SPECT attenuation correction scan or Radiation Therapy planning procedure. These procedures are eligible to count once towards the required 10 or more procedures that must be competed with a minimum of three (3) repetitions and maximum of five (5) repetitions.

***Instructions*:**

1. Select at least 10 different procedures out of the 53 procedures listed for adult and/or pediatric
2. Complete at least 3 and not more than 5 repetitions of each of the selected procedures
3. Complete a total of at least 50 repetitions across all of the selected procedures

Please indicate the date each procedure was performed by the applicant, number of repetitions, the facility or institution name where procedure was performed, and the supervisor of the applicant. Copies of this form may be made if the applicant has multiple clinical locations.

CT Procedure	Date(s) Completed	Number of Repetitions	Facility	Supervisor's Initials
Example: *Head with contrast*	*2/5, 2/6, 3/12, 3/18 and 3/19/25*	*Max of 5*	*Marie Curie Institute*	*MSC*
1. Head with contrast				
2. Head without contrast				
3. Head with and without contrast				
4. Brain perfusion				
5. Brain angio				
6. Facial bones/Mandible				
7. Temporal bones				
8. Orbits				
9. Sinuses				
10. Trauma head				
11. Soft tissue neck contrast				
12. Chest with contrast				
13. Chest without contrast				
14. Chest with and without contrast				
15. Chest Angio [PE]				
16. Heart				
17. Calcium Score				

18. Low dose lung screening				
19. High resolution Chest				
20. Cervical Spine				
21. Thoracic Spine				
22. Lumbar Spine				
23. Upper extremity				
24. Lower extremity				
25. Abdomen with contrast				
26. Abdomen without contrast				
27. Abdomen with and without contrast				
28. Abdomen and Pelvis with contrast				
29. Abdomen and Pelvis without contrast				
30. Abdomen and Pelvis with and without contrast				
31. Abdomen/Pelvis [Stone]				
32. Abdomen/Pelvis [Angio]				
33. Abdomen/Pelvis [Adrenal]				
34. Abdomen Multiphase [Kidney]				
35. Abdomen Multiphase [Liver]				
36. Abdomen Multiphase [Pancreas]				
37. Abdomen/Pelvis Multiphase [Multi-use]				
38. Head/Face				
39. Head/Face/Chest				
40. Head/Face/C-Spine/Chest				
41. Head/Face/C-Spine/Neck/Chest Angio				
42. Chest/Abdomen/Pelvis without contrast				
43. Chest/Abdomen/Pelvis with and without contrast				
44. Chest/Abdomen/Pelvis [Angio]				
45. Head/Face/C-Spine [Trauma]				
46. Head/C-Spine [Trauma]				
47. Head/Neck/Chest/Abdomen/Pelvis [Trauma]				
48. Heart Chest/Abdomen/Pelvis Angio				
49. Trauma [Misc.]				
50. Fiducial Marker Placement				
51. Pelvis with contrast				
52. Pelvis without contrast				
53. Pelvis with and without contrast				

**Procedures listed may include both adult and pediatric studies.*

CT Procedures Total:

Total # of CT Procedures Performed: _____ (Minimum of **10** Required)

Total # of Repetitions Performed: 0 _____ (Minimum of **50** Required)

Total # of CT Contrasted Procedures Performed: _____ (Minimum of **25** Required)

Authorized Representative* Attestation

**The Authorized Representative may be the applicant's Program Director, Clinical Coordinator, Supervising Physician, Technical Supervisor, or a NMTCB(CT) or ARRT(CT) credentialed employee of the facility*

I attest that the applicant listed above has demonstrated competency in Quality Assurance, including calibration checks, CT number, and standard deviation (water phantom) as part of the procedural requirements.

Authorized Representative #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**

Authorized Representative #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 four (4) pages are included in your transmission.