



APPLICATION FOR RADIOACTIVE MATERIAL LICENSE
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF AIR QUALITY
 SFN 8418 (RCP-10) (9-01)

INSTRUCTIONS - Complete Items 1 through 16 if this is an initial application or renewal application. If application is for renewal of a license, indicate new information or changes in the program. Use supplemental sheets if necessary. Mail one copy to: North Dakota Department of Health, Division of Air Quality, 1200 Missouri Avenue, Box 5520, Bismarck, ND 58506-5520. Upon approval of this application, the applicant will receive a Radioactive Material License, issued in accordance with the requirements contained in Article 33-10 of the North Dakota Department of Health Rules and Section 23-20.1-01 through 23-20.1-11 of Chapter 23-20.1 of the North Dakota Century Code.

1. (a) Name of Applicant (Institution, Firm, Hospital, Person, etc.)						
Address			City	State	Zip Code	
1. (b) Address of Radioactive Material Use (if different from above)			City	State	Zip Code	
2. Department to Use Radioactive Material (Attach organizational chart(s) showing corporate structure with the names of personnel responsible for radioactive material.)						
3. Previous License Number(s) (If this is an application for renewal of a license, please indicate and give number.)						
4. Authorized User(s) (Name and title of individual(s) who will use or directly supervise use of radioactive materials. Give training and experience in Items 8 and 9.)						
5. Radiation Safety Officer (Name of person designated as radiation safety officer. Attach resume of individual's training and experience as in Items 8 and 9, if other than individual user. Attach a detailed description of the duties and responsibilities of the RSO.)						
6. (a) Radioactive Material (Elements and mass number of each)						
6. (b) Chemical and/or Physical Form and Maximum Quantity of Each Chemical and/or Physical Form That You Will Possess at Any One Time (If sealed sources(s), also state name of manufacturer, model number, number of sources and maximum activity per source.)						
7. Describe Purpose for Which Radioactive Material Will Be Used. (If radioactive material is for "human use", applicant must demonstrate that they meet the training and experience requirements of Section 33-10-07-12 of the North Dakota Radiological Health Rules. If radioactive material is in the form of a sealed source, include make and model number of the storage container and/or device in which the source will be stored and/or used.)						
8. TYPE OF TRAINING	WHERE TRAINED	DURATION OF TRAINING	ON THE JOB		FORMAL COURSE	
			Yes	No	Yes	No
a. Principles and practices of radiation protection						
b. Radioactivity measurement standardization and monitoring techniques and instruments						
c. Mathematics and calculations basic to the use and measurement of radioactivity						
d. Biological effects of radiation						

9. EXPERIENCE WITH RADIATION (Actual use of radioisotopes or equivalent experience.)					
ISOTOPE	MAXIMUM AMOUNT	WHERE EXPERIENCE WAS GAINED	DURATION OF EXPERIENCE	TYPE OF USE	
10. RADIATION DETECTION INSTRUMENTS (Use supplemental sheets if necessary.)					
TYPE OF INSTRUMENTS (Include make and model of each)	NUMBER AVAILABLE	RADIATION DETECTED	SENSITIVITY RANGE (mr/hr)	WINDOW THICKNESS (mg/cm ²)	USE (Monitoring, Surveying, Measuring)
11. Method, Frequency, and Standards Used in Calibrating Instruments Listed Above.					
12. Film Badges, Dosimeters, and Bio-assay Procedures Used (For film badges, specify method of calibrating and processing, or name of supplier.)					

Information to be Submitted on Additional Sheets:

13. FACILITIES AND EQUIPMENT
Describe facilities and remote handling equipment, storage containers, shielding, fume hoods, etc. Attach explanatory sketch of facility.
14. RADIATION PROTECTION PROGRAM
Describe the radiation protection program including control measures. If application covers sealed sources, submit leak testing procedures where applicable. Name, training, and experience of person to perform leak tests and arrangements for performing initial radiation survey, servicing, maintenance and repair of the source should also be provided.
15. WASTE DISPOSAL
If a manufacturer or commercial waste disposal service is employed, specify name of company. Otherwise, submit detailed description of methods which will be used for disposing of radioactive wastes and estimates of the type and amount of activity involved.

CERTIFICATE
(This item must be completed by applicant)

16. THE APPLICANT AND ANY OFFICIAL EXECUTING THIS CERTIFICATE ON BEHALF OF THE APPLICANT NAMED IN ITEM 1, CERTIFY THAT THIS APPLICATION IS PREPARED IN CONFORMITY WITH NORTH DAKOTA DEPARTMENT OF HEALTH RADIOLOGICAL HEALTH RULES AND THAT ALL INFORMATION CONTAINED HEREIN, INCLUDING ANY SUPPLEMENTS ATTACHED HERETO, IS TRUE AND CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

Applicant Named in Item 1		Date
By		
Title of Certifying Official Authorized to Act on Behalf of the Applicant		
Person to be contacted regarding this application	Phone	
	Fax	
	Email	

Supplement A

Supplement A

ND Department of Health

TRAINING AND EXPERIENCE AUTHORIZED USER OR RADIATION SAFETY OFFICER

1. NAME OF PROPOSED AUTHORIZED USER OR RADIATION SAFETY OFFICER	2. FOR PHYSICIANS, STATE OR TERRITORY WHERE LICENSED
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3. CERTIFICATION

SPECIALTY BOARD A	CATEGORY B	MONTH AND YEAR CERTIFIED C

4. TRAINING RECEIVED IN BASIC RADIOISOTOPE HANDLING TECHNIQUES

FIELD OF TRAINING A	LOCATION & DATE(S) OF TRAINING B	TYPE AND LENGTH OF TRAINING	
		CLOCK HOURS IN LECTURE OR LABORATORY	CLOCK HOURS OF SUPERVISED ON-THE-JOB
a. RADIATION PHYSICS AND INSTRUMENTATION			
b. RADIATION PROTECTION			
c. MATHEMATICS PERTAINING TO THE USE AND MEASUREMENT OF RADIOACTIVITY			
d. RADIATION BIOLOGY			
e. RADIOPHARMACEUTICAL CHEMISTRY			

5. EXPERIENCE WITH RADIATION (Actual use of Radioisotopes or Equivalent Experience)

ISOTOPE	mCi USED AT ONE TIME	LOCATION	CLOCK HOURS	TYPE OF USE

SUPPLEMENT B

Supplement B	ND Department of Health
PRECEPTOR STATEMENT	

Supplement B must be completed by the applicant physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each.

1. PROPOSED PHYSICIAN USER'S NAME AND ADDRESS _____ NAME _____ STREET ADDRESS _____ CITY STATE ZIP CODE	<p align="center">CRITERIA FOR COLUMN C PERSONAL PARTICIPATION SHOULD CONSIST OF:</p> <ul style="list-style-type: none"> • Supervised examination of patients to determine the suitability for radioisotope diagnosis and/or treatment and recommendation for prescribed dosage. • Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data. • Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.
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2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE-NAMED PHYSICIAN

ISOTOPE A	USE OF RADIOACTIVE MATERIAL - PROCEDURES PERFORMED B	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION C	COMMENTS (Additional information or comments may be submitted on separate sheets.) D
	Thyroid scan		
	Thyroid uptake		
	Lung perfusion scan		
	Xenon ventilation study		
	Aerosol ventilation study		
	Aerosol ventilation scan		
	Renal flow scan		
	Brain scan		
	Liver/spleen scan		
	Bone scan		
	Gastroesophageal study		
	LeVeen shunt study		
	Cystogram		
	Dacryocystogram		
	Cardiac perfusion scan		
	Cardiac stress ventriculogram		
	Cardiac rest ventriculogram		
	Gallium scan		
Other:			

PROPOSED PHYSICIAN USER:

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE-NAMED PHYSICIAN (Continued)

ISOTOPE A	USE OF RADIOACTIVE MATERIAL - PROCEDURES PERFORMED B	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION C	COMMENTS (Additional information or comments may be submitted on separate sheets.) D
P-32 (soluble)	TREATMENT OF POLYCYTHEMIA VERA, LEUKEMIA, AND BONE METASTASES		
P-32 (Collodal)	INTRACAVITARY TREATMENT		
I-131	TREATMENT OF THYROID CARCINOMA		
	TREATMENT OF HYPERTHYROIDISM		
Au-198	INTRACAVITARY TREATMENT		
Co-60 or Cs-137	INTERSTITIAL TREATMENT		
	INTRACAVITARY TREATMENT		
I-125 or Ir-192	INTERSTITIAL TREATMENT		
Co-60 or Cs-137	TELE THERAPY TREATMENT		
Sr-90	TREATMENT OF EYE DISEASE		
	RADIOPHARMACEUTICAL PREPARATION		
Mo-99/ Tc-99M	GENERATOR		
Tc-99m	REAGENT KITS		
F-18	POSITRON EMISSION TOMOGRAPHY		
Ir-192	HIGH DOSE RATE REMOTE AFTERLOADING		
Other			

3. DATES AND TOTAL NUMBER OF HOURS RECEIVED IN CLINICAL RADIOISOTOPE TRAINING
 LOCATION DATES CLOCK HOURS OF EXPERIENCE

4. THE TRAINING AND EXPERIENCE INDICATED ABOVE WAS OBTAINED UNDER THE SUPERVISION OF: a. NAME OF SUPERVISOR _____ b. NAME OF INSTITUTION _____ c. MAILING ADDRESS _____ d. CITY, STATE, ZIP _____	6. PRECEPTOR'S SIGNATURE
	7. PRECEPTOR'S NAME (Please type or print)

5. MATERIALS LICENSE NUMBER(S):	8. DATE
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