

**APPLICATION FOR NUCLEAR MEDICINE SERVICE**

**Reply to:**

\_\_\_\_\_ **HOSPITAL NAME**

1. Name and board eligibility or certification status and other qualifications of physician responsible for the service:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Name and experience of radiological physicists available to the service: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Number of technologists available to the service: \_\_\_\_\_

4. Briefly describe scope of services provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Number of patient evaluations annually: \_\_\_\_\_