CHECKLIST – AUTHORIZATION TO TREAT

We request you to submit this checklist along with supporting documents to:

RHBRMT@cdph.ca.gov

Date: _____ State Facility Registration Number: FAC_____

Facility Name: _____

Physical Address: _____

Mailing Address: _____

Individual Responsible for the Facility (ex: Medical Director):

Name: _____ Title: _____

Facility Contact:

Name: _____ Title: _____

Phone: _____ Email: _____

Machine Make and Model: _____Serial Number: _____

Room (Vault) Name/Number: _____

All Photon Energies (MV): _____ All Electron Energies (MeV): _____

Radiation Machine Registration Form Tracking Number: _____

RADIATION PROTECTION AND SAFETY PROGRAM

☐ **Organization and Administration** – identifies key personnel and provides an overview of their functions.

☐ **ALARA** – acknowledges ALARA and will apply if necessary.

☐ **Dosimetry** – implements personnel monitoring if required, familiarity with dose limits for workers and the public.

☐ **Area Monitoring and Control** – overview of areas that need to be monitored; identifies type of instrumentation for monitoring.

☐ **Radiological Control** – overview of entry and exit controls, posting, signage, and proper disposal of equipment.

☐ **Emergency Exposure Situations and Radiation Accident** – overview of procedures and protocols for radiological incidents.

☐ **Record Keeping and Reporting** – overview of record keeping and reporting protocols.

☐ **Reports to Individuals** – overview of procedures for providing individual exposure reports.

☐ **Radiation Safety Training** – overview of training protocols and procedures for occupational and non-occupational workers.

☐ **Internal Audit Procedures** – overview of procedures, protocols, and frequency of audits.

RADIATION PROTECTION SURVEY REPORT

Date of Report: _____

Therapeutic Survey or Calibration Physicist:

Name: _____

Authorization Number: TSP_____ or TCP_____
(Not applicable if supervised by a Department-authorized TSP/TCP)

Supervising Medical Physicist (if any): _____

Authorization Number: TSP _____ or TCP_____

☐ Verification of the following functions:

☐ **Interlock** - Treatment room shall be provided with interlocks. It shall be possible to restore machine to full operation only from the control panel.

☐ **Door** - Where large power-driven doors offer the only access to the room, a minimum of one door shall be provided with an auxiliary means for being opened in case of power failure or mechanical breakdown.

☐ **Warning Signal Light** - A flashing red warning signal light energized only when the useful beam is “ON” shall be located adjacent to the entrance(s) to a therapy room.

☐ Physicist's evaluation of the integrity of the protective barriers.

☐ Occupational dose of 5000 mrem per year.

☐ Public dose of 100 mrem per year and 2 mrem in any one hour for unrestricted areas.

☐ ALARA met if occupational dose held to 500 mrem per year.

☐ Radiation protection survey performed by or under direct supervision of Department-approved therapy physicist.

☐ Meets leakage requirements.

☐ Engineering drawings demonstrating survey points. Reasonable and consistent with points in reference material.

☐ Conclusion meets regulatory requirements and signed by Department-approved therapy physicist.

☐ **COPIES of CERTIFICATES OF CALIBRATION – (completed within 2 years):**

Electrometer (Make and Model): _____

Serial Number: _____ Date of Calibration: _____

Ion Chamber (Make and Model): _____

Serial Number: _____ Date of Calibration: _____

Neutron Meter (Make and Model): _____

Serial Number: _____ Date of Calibration: _____

CALIBRATION AND ACCEPTANCE FOR TREATMENT REPORT

Date of Report: _____

Therapeutic Calibration Physicist:

Name: _____

Authorization Number: TCP_____
(Not applicable if supervised by a Department-authorized TSP/TCP)

Supervising Medical Physicist (if any): _____

Authorization Number: TCP_____

☐ Calibration of the output of the radiation therapy system performed by or under direct supervision of Department-approved therapy physicist prior to irradiation of patients.

☐ Machine is operating in compliance with design specifications (copy of manufacturer's acceptance report provided).

☐ Depth dose for each effective energy, field size, and treatment distance.

☐ Congruence of the radiation field and the localizing device.

☐ Uniformity, flatness, and symmetry of the treatment beam.

☐ Dose per unit time and per monitor setting.

☐ Transmission factors for beam modifiers (wedges, filters).

☐ Axis of rotation.

☐ TG-51 Report.

☐ Exposure rate and dose evaluated at all effective energies.

☐ Conclusion meets regulatory requirements and signed by Department-approved therapy physicist.

☐ Provided periodic (e.g., daily, weekly, monthly, annual) spot check procedures.

☐ Spot check procedures developed or approved by the individual who made the most recent calibration of the system.

☐ **COPIES of CERTIFICATES OF CALIBRATION – (completed within 2 years):**

Electrometer (Make and Model): _____

Serial Number: _____ Date of Calibration: _____

Ion Chamber (Make and Model): _____

Serial Number: _____ Date of Calibration: _____