



## **CORONARY CT ANGIOGRAPHY AND CARDIAC CT**

### **PROFESSIONAL PHYSICIAN/ PRACTICE ASSESSMENT**

*(Revised 2/21/2007)*

**Please complete the assessment below and return with all required documentation to:**

**CareCore National, LLC  
Attention: Credentialing Department  
400 Buckwalter Place Boulevard  
Bluffton, SC 29910**

Or fax all documentation to CCN Credentialing Department at 845-298-8384.

Only one application is required for the health plans that participate in the CareCore Cardiology Management Cardiac CT Specialty Center (CCTSC).

If you have questions, contact the CareCore National's Credentialing Department at 800-918-8924, ext 10190.

# MINIMUM REQUIREMENTS FOR CONSIDERATION

Supply copies of all documents, as applicable.

## Cardiac Imaging Specialist (CIS)

- ▶ Documentation of a minimum of 300 CCTA examinations within last two years. Documentation the physician was physically present and involved in the acquisition and interpretation of the cases.
- ▶ **For provider(s) applying after 6/30/2007-**
  - Documentation of a minimum of 100 CCTA examinations done independently at a site under direct supervision of CIS. This documentation must include a statement that the applicant was physically present and involved in the acquisition and interpretation of the cases.
  - Letter of documentation of at least 200 CCTA cases in which the candidate was involved in the interpretation of the examination.
- ▶ Proof of 40 hours of category I CME Credits in CCTA.
- ▶ A current Advanced Cardiovascular Life Support (ACLS) Certificate.

*For maintenance of a CIS status, a minimum of 150 CCTA cases per year must be documented as well as 40 hours of category I CME credits in CCTA every 3 (Three) years.*

## Cardiologist

- ▶ A valid unrestricted state license.
- ▶ Proof of completion of fellowship training at an approved Cardiology program.
- ▶ A copy of Cardiology Board certification or eligibility.
- ▶ A current Advanced Cardiovascular Life Support (ACLS) Certificate.

## Radiologist

- ▶ A valid unrestricted state license.
- ▶ Proof of Residency Certificate in General Radiology.
- ▶ Proof of prior training in CCTA and Cardiac CT such as fellowship training in CCTA/Cardiac CT or specialized “mini-fellowships” in CCTA sponsored by a North American Medical College.
- ▶ Documentation of supervised experience in the performance of Catheter or CT angiograms.
- ▶ A current Advanced Cardiovascular Life Support (ACLS) Certificate.
- ▶ Document of training in the use of all necessary pharmaceuticals.
- ▶ A copy of American Board Radiology (ABR) or American College of Cardiology (ACC) Certification(s).

## Senior CCTA Technician

- ▶ A current American Registry of Radiologic Technologists (ARRT) Certificate.
- ▶ A valid unrestricted state license.
- ▶ Documentation of training specifically in CT and CCTA.
- ▶ Documentation of having passed the advanced examination for the CT registry. (Documentation of training in the use of a powered dual-head contrast injector.)
- ▶ Documentation of performance of daily calibration of scanners to be used for CCTA and Cardiac CT.
- ▶ Documentation of certification in BLS.
- ▶ Proof of 24 CME credits in a two year period including a minimum of 6 credits specifically in CCTA/Cardiac CT.

### **CCTA Technician**

- ▶ A current American Registry of Radiologic Technologists (ARRT) Certificate.
- ▶ A valid unrestricted state license.
- ▶ Documentation of having passed the advanced examination for the CT registry within 12 months of beginning training in CCTA/ Cardiac CT.
- ▶ Documentation of training in CCTA/ Cardiac CT to include a minimum of 50 CCTA exams under the direct supervision of a senior Cardiac CT/ CCTA Technician.
- ▶ Documentation of training in the use of a powered dual-head contrast injector.
- ▶ Documentation of certification in BLS.
- ▶ Proof of 24 CME credits in a two year period including a minimum of 6 credits specifically in CCTA/Cardiac CT.

### **Medical Physicist**

- ▶ Documentation of accreditation in the subfields of Diagnostic Radiological Physics, , Diagnostic Imaging Physics, or Radiological Physics as required by the American Board of Radiology (ABR) or the American Board of Medical Physics (ABMP).
- ▶ A valid unrestricted state license.
- ▶ Documentation of Training in the use of multidetector CT scanning.
- ▶ Documentation of continuing education credits for Maintenance of Certification as required by the American Board of Radiology. Included in the continuing education requirements necessary to maintain board certification in your sub-specialty shall be 15 category one credits in CT (including CTA and multi-slice CT) every three (3) years.

### **Nurse/ Physician Assistant**

- ▶ A valid unrestricted state license.
- ▶ A current Advanced Cardiovascular Life Support (ACLS) Certificate.
- ▶ Documentation of training in the use of a powered dual head contract injector.

Please refer to the CCTSC Credentialing Standards located at [www.carecorecardiology.com](http://www.carecorecardiology.com) or [www.carecorenational.com](http://www.carecorenational.com)

As part of the CareCore Cardiology quality assurance program, periodically you may be requested to submit CCTA/Cardiac CT studies for our review. CareCore will evaluate these studies and determine the quality of the images, accuracy of the interpretation, adherence to contraindications (Appendix B), and to assure that the reporting format in accordance with the requirements (Appendix A).

### **Appendix A (Reporting Format)**

**Native vessels:** Report calcium score with calcium mass and volume per vessel. Discuss dominance, overall vessel size and number of diagonals and obtuse marginals, describe any anatomic variants. Describe lesion location by segment. Describe plaque composition as calcified, noncalcified or mixed. Describe severity as: Minimal; Mild: ~20-30%; Mild-moderate ~30-50%; Moderate ~ 50%; Mod-severe ~50-75%; or Severe > 75%. Discuss limitations of the study if any (blooming artifact, motion, quantum mottle).

**Stents:** Report location, patency, and any limitations of interpretation

**Bypass grafts:** Report location, patency, and any lesions in the native vessels distal to the graft touchdown point. Report any limitations of interpretation (i.e. clip artifact)

**LV function:** Report EF, ES volume and ED volume on all patients. Evaluate and report any apparent subendocardial perfusion defects, any regions of myocardial or septal thinning or hypertrophy, and any abnormalities of myocardial contractility. Evaluate valve morphology and motion and report any apparent abnormalities.

**Other:** Report any extracardiac abnormalities (i.e. lung nodules, hiatal hernia, etc)

**Appendix B (Relative contraindications to CCTA)**

1. Atrial Fibrillation
2. Multifocal Atrial Tachycardia (MAT)
3. Frequent Atrial Premature Contractions
4. >50 Premature Ventricular Contractions/Hour
5. Inability to lie flat
6. Inability to obtain heart rate < 65 beats per minute after beta-blockers
7. Calcium Score > 1000\*
8. Normal Catheterization < 1 year ago
9. Body mass index  $\geq$  40% (see BMI Chart)
10. Inability to breath hold > 8 seconds

# CORONARY CT ANGIOGRAPHY AND CARDIAC CT PROFESSIONAL PHYSICIAN/PRACTICE ASSESSMENT

*Please print all fields*

## CARDIAC IMAGING SPECIALIST (CIS)

Name: \_\_\_\_\_  
Last Name First Name MI

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Social Security # \_\_\_\_\_ Degree(s) \_\_\_\_\_  
MD, DO, Other

National Provider Identifier # \_\_\_\_\_ Date of Birth \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ UPIN # \_\_\_\_\_

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/year mm/year

Medicare ID # \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

## PRACTICE INFORMATION

Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_ E-mail: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_ National Provider Identifier (NPI) \_\_\_\_\_

Website: \_\_\_\_\_ Contact Person: \_\_\_\_\_

## BILLING INFORMATION

Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_ Contact Person \_\_\_\_\_

**OWNERSHIP STRUCTURE**

**Owner’s Name, Address, Telephone, Fax, and Tax ID Number** (If different than above):

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**Operational Structure** (check all that apply):

- |                                                     |                                                        |                                                |
|-----------------------------------------------------|--------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Corporation                | <input type="checkbox"/> Limited Liability Company     | <input type="checkbox"/> Government            |
| <input type="checkbox"/> Not-For-Profit Corporation | <input type="checkbox"/> Professional Corporation      | <input type="checkbox"/> Partnership           |
| <input type="checkbox"/> Sole Proprietorship        | <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Faculty Practice Plan |
| <input type="checkbox"/> Subsidiary                 |                                                        |                                                |

\*If more than one is checked, please explain: \_\_\_\_\_

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\*If Subsidiary, name and address of Parent Company \_\_\_\_\_

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**Physicians\*** –List all physicians who practice at this site and their relationship to this site, e.g., shareholder, partner, member, employee, etc. Please list board certification status of each physician and, if board eligible, date of initial board eligibility. *\*Attach a separate sheet if needed*

Physician Name	State	State License Number	NPI # Required	CIS Applicants	Board Certified Yes/No?	If yes, name of Board	If no, date eligible

*Note: All MDs must meet requirements noted on page 1 and supply supporting documentation as requested for consideration. All CIS Applicants noted above must complete the Cardiac Imaging Specialist (CIS) section.*

**Do any physicians who make referrals to your practice have any of the following financial relationships with your practice:**

- a) Have an ownership or other financial interest in any of the equipment utilized by your practice?  
 **Yes**     **No**
  
- b) Have an ownership or other financial interest in any of the office space utilized by your practice?  
 **Yes**     **No**
  
- c) Have any form of a compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing, etc.)?  **Yes**     **No**

**Is the facility shared with any other physician, physician group, or other legal entity?**

**Yes**     **No**

**Contact Names/Telephone Numbers/Email Addresses:**

Medical Director: \_\_\_\_\_ Specialty \_\_\_\_\_

Office Manager: \_\_\_\_\_

**Days and Hours of Operation:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

**EQUIPMENT – DESCRIPTION**

*If your facility operates more than one of the following pieces of equipment, please complete a copy of this section for EACH machine.*

**Coronary CTA/ Computerized Tomography:** All fields must be completed and answered.

ACR Accredited  Yes\*  No *(\*If YES, attach certificate)*  
 In Process; Date of Application: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Software Version \_\_\_\_\_

Model Description: \_\_\_\_\_ Model #: \_\_\_\_\_

Date Manufactured: \_\_\_\_\_ Date Installed: \_\_\_\_\_

Date of Last Software Upgrade: \_\_\_\_\_ # Slices per Rotation: \_\_\_\_\_  
 Fixed  Mobile                      DICOM Compatible  Yes  No

**Please answer all questions below:**

Is your CT scanner capable of creating a minimum 64 slices per gantry rotation for a Coronary CT angiography?  
 Yes  No

How much time does it take for a complete gantry rotation? \_\_\_\_\_

Tube heat capacity allows for a single > 20 second acquisition  Yes  No

Do you have capabilities of performing ECG gated acquisitions?  Yes  No

What is the minimum section thickness in millimeters? \_\_\_\_\_

Do you use a powered dual-head contrast medium injector?  Yes  No

Do you save all studies reconstructed in DICOM format for seven (7) years?  Yes  No

## EDUCATION/TRAINING/ BOARD CERTIFICATION

### Cardiac Imaging Specialist (CIS)

*Please duplicate and complete this section for each Cardiac Imaging Specialist (CIS) in your practice.  
Please refer to the Credentialing standards and supply copies of all documentation as indicated.*

Name: \_\_\_\_\_  
Last Name First Name MI Degree, MD, DO, Other

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Social Security # \_\_\_\_\_ UPIN # \_\_\_\_\_

National Provider Identifier # \_\_\_\_\_ Date of Birth \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ Medicare ID # \_\_\_\_\_

Issued Date \_\_\_\_\_ / \_\_\_\_\_ Exp. Date \_\_\_\_\_ / \_\_\_\_\_ Medicaid ID# \_\_\_\_\_  
mm/year mm/year

Medical School: \_\_\_\_\_ State/ Country \_\_\_\_\_

Dates Attended From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Degree Obtained \_\_\_\_\_  
mm/year mm/year

Residency: \_\_\_\_\_

Dates Attended From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Specialty \_\_\_\_\_  
mm/year mm/year

Are you certified by the Accreditation Council for Medical Education (ACGME)?  Yes  No

Fellowship: Specialty/ Program: \_\_\_\_\_

Dates Attended From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Was program completed?  Yes  No  
mm/year mm/year

Did your fellowship training include CTA, cardiovascular imaging or cardiovascular radiology including CCTA/Cardiac CT, specialized "mini fellowships" in CCTA sponsored by North American Medical College?

Yes  No If not, must provide other form of specialized training and/or experience in CCTA/Cardiac CT.

Primary Specialty \_\_\_\_\_ Board Certified?  Yes  No

Name of Certifying Board: \_\_\_\_\_

Initial Certification Date \_\_\_\_\_ / \_\_\_\_\_ Expiration Date \_\_\_\_\_ / \_\_\_\_\_ Board Eligible?  Yes  No  
mm / year mm / year

Secondary Specialty \_\_\_\_\_ Board Certified?  Yes  No

Name of Certifying Board: \_\_\_\_\_

Initial Certification Date \_\_\_\_\_ / \_\_\_\_\_ Expiration Date \_\_\_\_\_ / \_\_\_\_\_ Board Eligible?  Yes  No  
mm / year mm / year

**Cardiac Imaging Specialist (CIS) continued**

Name: \_\_\_\_\_  
Last Name First Name MI

**CIS's currently performing CCTA/ Cardiac CT, please answer questions below:**

Have you independently performed a minimum of 300 CCTA examinations within the last two years?  Yes  No If so, provide a letter of documentation confirming the above question. The letter must also include a statement that the applicant was physically present and involved in the acquisition and interpretation of the cases.

How many Category I CME Credits have you obtained in CCTA? \_\_\_\_\_

For maintenance of CIS status, do you agree to document a minimum of 150 CCTA cases per year?  Yes  No

For maintenance of CIS status, do you also agree to maintain 40 hours of Category I CME Credits in CCTA every (3) three years?  Yes  No

Do you agree to submit all CCTA reports rendered by your site(s) for the purpose of data collection and research?  Yes  No Please note, all reports must comply with the reporting format required by CCCM (see Appendix A).

Do you agree to adhere to the relative contraindications for CCTA listed in Appendix B?  Yes  No

Have you been trained in Advanced Cardiovascular Life Support (ACLS)?  Yes  No  
Issued Date \_\_\_\_ / \_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

**For CIS applying after 6/30/2007, please answer all questions below:**

Have you independently performed a minimum of 100 CCTA examinations at a site under direct supervision of a CIS?  Yes  No If so, must provide a letter of documentation confirming the above. The letter must be from the supervising CIS physician attesting the applicant has successfully and independently performed a minimum of 100 CCTA examinations including documentation that the applicant was physically present and involved in the acquisition and interpretation of the cases.

Have you been involved in the interpretation of the examination of at least 200 CCTA cases?  Yes  No  
If so, provide a letter of documentation confirming above question.

How many Category I CME Credits have you obtained in CCTA? \_\_\_\_\_

For maintenance of CIS status, do you agree to document a minimum of 150 CCTA cases per year?  Yes  No

For maintenance of CIS status, do you also agree to maintain 40 hours of Category I CME Credits in CCTA every (3) three years?  Yes  No

Do you agree to submit all CCTA reports rendered by your site(s) for the purpose of data collection and research?  Yes  No Please note, all reports must comply with the reporting format required by CCCM (see Appendix A).

Do you agree to adhere to the contraindications for CCTA listed in Appendix B?  Yes  No

Have you been trained in Advanced Cardiovascular Life Support (ACLS)?  Yes  No  
Issued Date \_\_\_\_ / \_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

***I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND ACCURATE.***

**Provider Name: (Please Print):** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Senior CCTA Technician**

*Please duplicate and complete this section for each Senior CCTA Technician in your practice.  
Please refer to the Credentialing standards and supply copies of all documentation as indicated.*

Name: \_\_\_\_\_  
Last Name First Name MI Degree

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Social Security # \_\_\_\_\_ UPIN # \_\_\_\_\_

National Provider Identifier # \_\_\_\_\_ Date of Birth \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ Medicare ID # \_\_\_\_\_

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicaid ID# \_\_\_\_\_  
mm/year mm/year

Do you have a valid unrestricted license?  Yes  No License # \_\_\_\_\_ State \_\_\_\_\_

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm / year mm / year

Are you certified with American Registry of Radiologic Technologists (ARRT)?  Yes  No

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

Do you have documented training and experience in CT?  Yes  No

Have you passed the advanced examination for the CT registry?  Yes  No

Have you been trained on how to operate CT equipment and knowledgeable in radiation physics and protection with documented evidence of such training and experience?  Yes  No

Do you perform daily calibration of scanners to be used for CCTA and Cardiac CT?  Yes  No

Do you comply with ARRT requirements for continuing education appropriate to your practice?  Yes  No

Have you achieved 24 CME credits in a two-year period including a minimum of 6 credits specifically in CCTA/Cardiac CT?  Yes  No

Have you been trained in the use of powered dual-head contrast injector?  Yes  No

Have you been trained in Basic Life Support (BLS)?  Yes  No

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

**I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND ACCURATE.**

**Provider Name: (Please Print):** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CCTA Technician**

*Please duplicate and complete this section for each CCTA Technician in your practice.  
Please refer to the Credentialing standards and supply copies of all documentation as indicated.*

Name: \_\_\_\_\_  
Last Name First Name MI Degree

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Social Security # \_\_\_\_\_ Degree(s) \_\_\_\_\_

National Provider Identifier # \_\_\_\_\_ Date of Birth \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ UPIN # \_\_\_\_\_

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/year mm/year

Medicare ID # \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Do you have a valid unrestricted license?  Yes  No License # \_\_\_\_\_ State \_\_\_\_\_  
Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm / year mm / year

Are you certified with American Registry of Radiologic Technologists (ARRT)?  Yes  No  
Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

Do you have documented training and experience in CT?  Yes  No

Have you passed the advanced examination for the CT registry?  Yes  No (If no, answer \*)  
Do you agree to provide documentation of passing the advanced examination for the CT registry within 12 months of beginning training in CCTA/ Cardiac CT?  Yes  No

Have you performed a minimum of 50 CCTA examinations under direct supervision of a senior Cardiac CT/ CCTA Technician?  Yes  No  
Have you achieved 24 CME credits in a two-year period including a minimum of 6 credits specifically in CCTA/Cardiac CT?  Yes  No

Have you been trained on how to operate CT equipment and knowledgeable in radiation physics and protection with documented evidence of such training and experience?  Yes  No

Have you been trained in the use of powered dual-head contrast injector?  Yes  No

Have you been trained in Basic Life Support (BLS)?  Yes  No  
Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

***I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND ACCURATE.***

**Provider Name: (Please Print):** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nurse/ Physician Assistant**

*Please duplicate and complete this section for each Nurse/ Physician Assistant in your practice.  
Please refer to the Credentialing standards and supply copies of all documentation as indicated*

Name: \_\_\_\_\_  
Last Name First Name MI Degree

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Social Security # \_\_\_\_\_ Degree(s) \_\_\_\_\_

National Provider Identifier # \_\_\_\_\_ Date of Birth \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ UPIN # \_\_\_\_\_

Issued Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm/year mm/year

Medicare ID # \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Do you have a valid license?  Yes  No License # \_\_\_\_\_ State \_\_\_\_\_  
Issued Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm / year mm / year

Have you been trained in Advanced Cardiovascular Life Support (ACLS)?  Yes  No  
Issued Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Certificate ID \_\_\_\_\_  
mm / year mm / year

Have you been trained and have documentation in the use of a powered dual head contrast injector?  Yes  No

Have you been trained in the administration of drugs used during CCTA procedures as well as their side effects and emergent treatment that may be required for any toxicity?  Yes  No

***I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND ACCURATE.***

**Provider Name: (Please Print):** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Medical Physicist

*Please duplicate and complete this section for each Medical Physicist associated with your practice.  
Please refer to the Credentialing standards and supply copies of all documentation as indicated*

Name: \_\_\_\_\_  
Last Name First Name MI Degree

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_ E-mail: \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_ UPIN # \_\_\_\_\_

Issued Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/year mm/year

Are you accredited in the subfields of Diagnostic Radiological Physics, Diagnostic Imaging Physics, or Radiological Physics as required by the American Board of Radiology (ABR) or the American Board of Medical Physics (ABMP)?  Yes  No

Are you licensed?  Yes  No

Are you familiar with the principles of imaging physics and radiation protection?  Yes  No

Are you familiar with the following principles?

- Imaging physics and of radiation protection?  Yes  No
- The guidelines of the National Council on Radiation Protection and Measurements?  Yes  No
- Laws and regulations pertaining to the performance of the equipment being tested?  Yes  No
- The function and clinical uses of CCTA and Cardiac CT?  Yes  No
- Performance specifications of the imaging equipment used for Cardiac CT and CCTA?  Yes  No
- Calibration processes and limitations of the instruments used for performance testing?  Yes  No

Do you have trained individuals assisting you in obtaining data?  Yes  No

If so, these individuals must be approved by the qualified medical physicist in the techniques of performing tests, the function and limitations of the imaging equipment and test instruments, the reason for the tests and the importance of the test results.

Do you agree to provide documentation of continuing education credits for Maintenance of Certification as required by the American Board of Radiology? Included in the continuing education requirements necessary to maintain board certification in your sub-specialty shall be 15 category one credits in CT (including CTA and multi-slice CT) every three (3) years.  Yes  No

***I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND ACCURATE.***

Provider Name: (Please Print): \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_