COLORADO
Department of Public Health & Environment

Application for Registration:
Provisional Registered Medical Physicist

This form is an application for registration as a Colorado Provisional Registered Medical Physicist for performing certification evaluations of x-ray producing machines and facilities. The registration is for a one year period. Renewals must be received 30 days prior to the expiration date. Please refer to 6 CCR 1007-1 *Colorado Rules and Regulations Pertaining to Radiation Control* Part 2, Appendix 2I for additional information.

New Application _____ ($100 fee) Renewal Application _____ ($100 fee)

Addition of new inspection category _____ ($60 fee)

Applicant Information: QI # _____ Registration Expiration Date: _____

Name: _____

Mailing Address: Street _____

City, State, Zip _____

Email Address: _____

Office Phone: _____ Mobile Phone: _____

Preferred contact method: Office Phone _____ Mobile Phone _____ Email _____ (Select only one. Email will be default if no selection made)

Qualifications (Required for new applications only)
Education: ☐ Bachelors ☐Masters (MS) ☐PhD Major _____ (attach copy of diploma or transcripts)

Experience: _____ Number years of experience as required in 6 CCR 1007-1, Part 2, appendix 2I.1.2

Machine Evaluation Categories requested: check each category you are requesting
- ☐ Dental (includes panoramic)
- ☐ Dental Cone Beam CT
- ☐ Veterinary (Includes veterinary dental)
- ☐ General Purpose Diagnostic Radiography (Includes general diagnostic, bone densitometry)
- ☐ Analytical – Non healing Arts (Includes package scanners, PMIs, cabinet analytical)
- ☐ Industrial Radiography

Professional Certification and status – Attach copy of certificate, authorization letter, or other documentation of your status with the organization
- ☐ American Board of Radiology
- ☐ American Board of Medical Physics
- ☐ Canadian College of Physicists in Medicine
- ☐ American Board of Science
- ☐ Other

Provisional (Supervised) categories – Attach training plan for the categories selected below
- ☐ Special Format Diagnostic Radiography (Includes CT, Fluoroscopy)
- ☐ Therapeutic Radiation (additional required qualifications listed in 6 CCR 1007-1, Part 2, Appendix 2I.5)

Supervising RMP Name & RMP # _____

As the Provisional Registered Medical Physicist sponsor, I agree to provide supervision to the applicant as outlined in the attached training program.

_____ _____
Signature of Supervising RMP **Date**

New Client Preferences (select only one)
- ☐ Accepting new clients
- ☐ Private employer only
- ☐ Not accepting clients at this time

Geographic coverage (select one only)
- ☐ All of Colorado
- ☐ Front Range only
- ☐ Western Slope only

Personnel Dosimetric Monitoring
Applicant is in possession of a personnel dosimeter to monitor occupational dose limits as outlined in 6 CCR 1007-1, Part 4.6

☐ Yes ☐ No

Personnel dosimetry supplier: _____ Dosimetry supplier's NVLAP Lab code: _____

Instrumentation Calibration:
Applicant will perform all certification evaluations and radiation exposure surveys with instruments that are in compliance with 6 CCR 1007-1, Part 2.4.4.6, maintained in good working order, and calibrated at least every two (2) years, or in accordance with the manufacturer's recommendation, whichever is more frequent, or after any repair that could affect the calibration of the instrument.

☐Yes ☐ No

I certify by my signature below under penalty of law that this application is prepared in conformity with the Colorado Department of Public Health and Environment's 6 CCR 1007-1 *Rules and Regulations pertaining to Radiation Control* and that all information contained herein, including any attachments, is true, accurate and complete to the best of my knowledge and belief. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

_____ _____

Applicant's Signature and Title **Date of Application**

Payment: Applicant will be invoiced (invoiced applicants may use the CDPHE on-line payment portal which accepts echeck, Debit and Credit Cards)

Send completed form with all attachments to
Email: cdphe_xray_qisc@state.co.us

Mail:
Colorado Department of Public Health and Environment
HMWMD- XRC –B1
4300 Cherry Creek Drive South
Denver, CO 80246-1530

For Office Use Only

Application received date: _____
Payment:
Check #_____ Check date _____ Amt. of Payment $_____ _____CDPHE Staff Initials

Invoice # _____ Date: _____

☐ **Approved** ☐ **Denied -** Reason for denial: _____

Approval/Denial date: _____ **R**eviewed by: _____

Supervisor review date: _____

Registration letter sent date : _____ by _____ ☐Email ☐Mail

An electronic copy of this form may be found at: https://www.colorado.gov/cdphe/xray