



**State of Colorado**  
**Department of Public Health and Environment**  
**R-81 Didactic Training and Clinical Experience**  
**For Bone Densitometry Equipment Operator**

INSTRUCTIONS: This form must be attached to Form R-80 to complete the application process. Applicants with certificates from the International Society of Clinical Densitometry (ISCD) are not required to complete this form. Please provide all information requested on this form. There must be signatures in each affirmation section. For questions about completing this form, please call (303) 692-3448 or (888) 569-1831 ext. 3448 toll-free (outside the 303 area code) or fax (303) 691-7841 Attention: X-Ray Certification Unit.

Student Name:		SSN (Last four digits)
<b>Didactic Requirement (Colorado Rules and Regulations Pertaining to Radiation Control, 6 CCR 1007-1, Part 2, Appendix 2F, Section 2F.2.1)</b> The student must complete at least 30 hours of classroom training in the following topics: <b>Basic X-ray Physics (2 Hours), Radiobiology (2 Hours), Radiation Protection (5 Hours), Basic Concepts (8 Hours), Equipment Operation and Quality Control (6 Hours), DXA Scanning of Forearm (2 Hours), DXA Scanning of Finger and Heel (1 Hour), DXA Scanning of Lumbar Spine (2 Hours), DXA Scanning of Proximal Femur (2 Hours).</b>		
Name of School		
Address		
City	State	Zip Code
Beginning Date:	Ending Date:	
Educator Name:	Phone:	
<b>Educator Affirmation</b> I affirm that the student has fulfilled the requirements of 6 CCR 1007-1, Part 2, Appendix 2F, Section 2F.2.1.		
Educator Signature		Date:
<b>Clinical Requirement (Part 2, Appendix 2F, Section 2F.2.2 and 2F.2.3)</b> The student must complete at least 480 hours of clinical experience under personal supervision of a qualified trainer (supervisor is physically present in the room during the procedure). No more than 160 hours may come from non-clinical, laboratory experience. During the clinical experience the student must perform at least 10 each of the following imaging exam procedures: <b>DXA scanning of Forearm, DXA scanning of Lumbar Spine, and DXA scanning of Proximal Femur .</b>		
Name of Clinic		Facility Registration #
Clinic Address		
City	State	Zip Code
Beginning Date:	Ending Date:	
Name of Supervisor		
<b>Supervisor Affirmation</b> I affirm that the student has fulfilled the requirements of 6 CCR 1007-1, Part 2, Appendix 2F, Sections 2F.2.2 and 2F.2.3 as described above.		
Supervisor Signature:		Date:
<b>Student Affirmation</b> I affirm that I have fulfilled the requirements of 6 CCR 1007-1, Part 2, Appendix 2F, Sections 2F.2.1, 2F.2.2, and 2F.2.3 and that all the information entered on this application is true and correct.		
Student Signature:		Date:

**Office Use Only**

Approval  Denial

Reviewer signature:	Date
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Supervisor Signature:	Date
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