

**TRAINING, EXPERIENCE AND PRECEPTOR ATTESTATION - E**  
**Authorized User of Remote Afterloader, Teletherapy or Gamma Stereotactic Radiosurgery Units)**

**This form has been revised and renumbered. Please update your link to:**

**<http://dhs.wisconsin.gov/forms/F4/F45010E.pdf>**

Preparing Treatment Plans and Calculating Treatment Times and Doses		
Using Administrative Controls to Prevent a Medical Event Involving the Use of Radioactive Material		
Implementing Emergency Procedures to be Followed in the Event of the Abnormal Operation of the Medical Unit or Console		
Checking and Using Survey Meters		
Selecting the Proper Dose and How It Is to be Administered		

**7. Supervised Clinical Experience in Radiation Therapy**

Type of Use	Number of Cases Involving Personal Participation	Location	Dates of Experience

**8. Supervising Individual – Identification and Qualifications**

If more than one supervising individual is needed to meet requirements in Wisconsin Administrative Code, HFS 157 Subchapter VI, provide the following information for each:

- Supervisor meets the requirements of s. HFS 157.67(17) or equivalent NRC or Agreement State requirements for the type(s) of use for which the individual named in Item 1 is seeking authorization.

Name of Supervising Individual

Name of License on which Supervising Individual is Authorized

Materials License Number (Indicate which state or if NRC)

**PART II PRECEPTOR ATTESTATION**

**NOTE:** This part must be completed by the individual's preceptor. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**9. Preceptor Approval and Attestation**

- I meet DHFS requirements to be a preceptor authorized user for the type(s) of use for which the individual named in Item 1 is seeking authorization.

I attest that the individual named in Item 1 has:

- satisfactorily completed the training requirements in s. HFS 157.67(17)

AND

- achieved a level of competency sufficient to function independently as an authorized user of each type of therapeutic medical unit for which the individual is requesting authorized user status.

Name of License on which Preceptor is Authorized

Materials License Number (Indicate which state or if NRC)

Print Name of Preceptor

SIGNATURE – Preceptor

Date Signed