

4. LOCATION(S) OF USE (Attach location map or building plan.)

Address (Department/Section,
 Room No., Building): _____
 Telephone Number: _____
 Fax Number: _____
 E-Mail Address: _____

5. PROPOSED WORKERS (Accomplish Attachments A, B, C and D for the training and experience of each person named below and submit certificates of relevant trainings).

Worker	Name	Position/Title	Other Affiliated Institutions
Authorized Users (Physicians)	_____ _____ _____	_____ _____ _____	_____ _____ _____
Medical Physicist			
Radiation Safety Officer (RSO)			
Assistant RSO			
Radiotherapy Technologists	_____ _____ _____	_____ _____ _____	_____ _____ _____

6. REPRESENTATION IN THE RADIATION SAFETY COMMITTEE. List the names of the members that compose the committee and their position or designation in the Institution, educational degree, address (department, building, room number) in the hospital, and telephone number. Use separate sheet.

7. FACILITIES (Use separate sheets if necessary).

Description of the Facility. Describe the facilities and submit annotated plans and drawings or sketches of rooms where radioactive material will be used and stored, indicating wall thickness, materials of construction, shielding, conduits or ventilation ducts. Describe the viewing systems, warning systems and safety interlock systems and adjacent areas.

Description of Isolation Room for Radioactive Patients. Describe the isolation room and provide a sketch of the room showing bed location, toilet and bathroom, dimensions, materials of construction, wall thickness, provisions for ventilation and description and level of occupancy of the adjacent areas. Provide dose rate and shielding calculations.

8. EQUIPMENT/INSTRUMENTS/DEVICES

8.1 Equipment

(a) For Remote After-Loading Brachytherapy Unit.

Type of radioactive source: _____
 Manufacturer of the equipment: _____
 Date of manufacture: _____
 Model number of the equipment: _____
 Serial number of the equipment: _____
 Date of purchase: _____
 Name & Address of institution who will provide repair and maintenance service on the equipment: _____
 Power output of the machine: _____
 Equipment features such as alarms, electrical interlocks, and automatic source withdrawal interlock: _____
 International standards to which the equipment and sources conform (e.g., IEC, ISO): _____

(b) For Manual After-Loading Device

Source storage and transport container: _____
 Source handling devices and accessories (such as tongs, lead containers, etc.): _____
 Radiation protection barrier during manual source loading in patient: _____

8.2 Radiation Detection/Measurement Survey Instruments

Type of Instrument	Model No./ Serial No.	Manufacturer	Radiation Detected (α, β, γ , etc.)	Sensitivity Range (mSv/h)	Window Thickness (mm)	Intended Use	Date of Initial Use

8.3 Personnel Monitoring Devices

Film Badge No. of Units _____
 TLD No. of Units _____
 Pen Dosimeter No. of Units _____
 Others No. of Units _____

9. RADIATION SAFETY PROGRAM. (Check appropriate space and attach the required information. Additional specific procedures may be required as may be deemed necessary.)

	Description Attached	Remarks
9.1 ALARA Program	<input type="checkbox"/>	_____
9.2 RSC Duties & Responsibilities	<input type="checkbox"/>	_____
9.3 RSO Authorities, Duties and Responsibilities	<input type="checkbox"/>	_____
9.4 Training Program	<input type="checkbox"/>	_____
9.5 Personnel Monitoring Program	<input type="checkbox"/>	_____
9.6 Calibration of Survey Instruments	<input type="checkbox"/>	_____
9.7 Leak Test Program	<input type="checkbox"/>	_____
9.8 Radiation Survey Program	<input type="checkbox"/>	_____
9.9 Operating Procedures	<input type="checkbox"/>	_____
9.10 Radiation Control Procedures		_____
– Procedure for Release of Patients with Permanent Implants	<input type="checkbox"/>	_____
– Procedure for Release of Patients with Temporary Implants	<input type="checkbox"/>	_____
– Procedure for Control of Public Exposure	<input type="checkbox"/>	_____
– Procedure for Visitor Control	<input type="checkbox"/>	_____
9.11 Emergency Procedures	<input type="checkbox"/>	_____
9.12 Decommissioning Plan	<input type="checkbox"/>	_____

10. SECURITY OF SEALED SOURCES. For Category 2 sources, submit a Security Plan in accordance with CPR Part 26; for Category 4 & 5 sources, e.g., Cs-137 and I-125, submit security measures.

11. MANAGEMENT OF DISUSED SEALED SOURCES. Submit a detailed description of methods of disposal of disused sealed sources. If disused sealed sources are to be returned to original supplier or manufacturer, submit a copy of agreement with the original supplier or manufacturer.)

12. APPLICATION FEE _____ Official Receipt No. _____
 Date: _____

LICENSE FEE _____ Official Receipt No. _____
 Date: _____

13. CERTIFICATION.

The applicant understands that all statements and representations made in this application are binding upon the applicant. The applicant or any official executing this certification on behalf of the applicant certifies that this application is prepared in conformity with the applicable requirements in the Code of PNRI Regulations and that all information contained herein are true and correct to the best of his knowledge and belief.

 Signature of Certifying Official
 Over Printed Name

 Title/Position of Certifying Official

 Date

14. ACKNOWLEDGEMENT.

{Republic of the Philippines}
{ }

Before me, a Notary Public for and in the above jurisdiction, personally appeared the following persons:

_____ CTC No. _____ Date/Place Issued _____

_____ CTC No. _____ Date/Place Issued _____

both known to me to be the same persons who executed the foregoing application and all attachments, and acknowledged to me the same to be their free and voluntary act and deed.

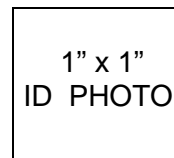
Notary Public

Doc. No. _____
Page No. _____
Book No. _____
Series of _____

ATTACHMENT A

**TRAINING AND EXPERIENCE OF
 PROPOSED AUTHORIZED USER**

NAME : _____
NAME OF INSTITUTION: _____
EDUCATIONAL DEGREE: _____



1. TRAINING RECEIVED IN BASIC RADIATION SAFETY

(Enclose certificates of training and use additional sheets if necessary.)

Field of Training	Location of Training	Date of Training	Duration of Training (Hours)		
			Lecture	Laboratory	On -the-Job
Radiation Physics & Instrumentation					
Radiation Protection					
Mathematics & Calculations Pertaining to the Use & Measurement of Radioactivity					
Radiation Biology					
Nuclear Regulations & Licensing					

2. WORK /CLINICAL EXPERIENCE IN THE USE OF BRACHYTHERAPY SOURCE

Radioactive Source (Element & Mass No.)	Maximum Activity (Becquerels)	Where Experience was Gained	Duration of Experience (Months)	Type of Use

3. RELEVANT TRAININGS (Submit certificates of relevant trainings.)

Title of Training	Place of Training	Date of Training

4. CERTIFICATION (Indicate the name of the Body that certified you to practice therapeutic radiology or similar disciplines and submit a copy of the certification).

Certifying Body	Date of Certification

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

 Signature of Proposed Authorized User

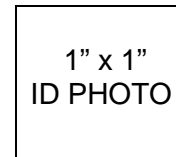
 Date

Endorsed by: _____
Chairman, Radiation Safety Committee
 Date: _____

ATTACHMENT B

**TRAINING AND EXPERIENCE OF
 PROPOSED MEDICAL PHYSICIST**

NAME : _____
NAME OF INSTITUTION: _____
EDUCATIONAL DEGREE: _____



1. TRAINING RECEIVED IN BASIC RADIATION SAFETY

(Enclose certificates of training and use additional sheets if necessary.)

Field of Training	Location of Training	Date of Training	Duration of Training (Hours)		
			Lecture	Laboratory	On-the-Job
Radiation Physics and Instrumentation					
Radiation Dosimetry					
Radiation Protection					
Radiation Biology					
Radiation Therapy					

2. EXPERIENCE WITH RADIATION AND RADIOACTIVE MATERIAL

Radioactive Source (Element & Mass No.)	Maximum Activity (Becquerels)	Where Experience was Gained	Duration of Experience (Months)	Type of Use of Radioactive Source

3. EXPERIENCE WITH A BRACHYTHERAPY UNIT

Equipment (Brand Name, Model/Serial Numbers)	Radioactive Source (Element & Mass No.)	Activity of the Source (Becquerels)	Experience Gained	Place where Experience was Gained	Duration of Experience (Months)

4. RELEVANT TRAININGS (Submit certificates of relevant trainings.)

Title of Training	Place of Training	Date of Training

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Proposed Medical Physicist

 Date

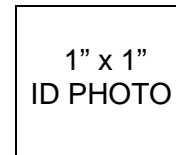
Endorsed by: _____
Chairman, Radiation Safety Committee

Date: _____

ATTACHMENT C

**TRAINING AND EXPERIENCE OF PROPOSED
 RADIATION SAFETY OFFICER**

NAME : _____
NAME OF INSTITUTION: _____
EDUCATIONAL DEGREE: _____



1. TRAINING IN BASIC RADIOISOTOPE HANDLING TECHNIQUES

(Enclose certificates of training and use additional sheets if necessary.)

Field of Training	Location of Training	Date of Training	Duration of Training (Hours)		
			Lecture	Laboratory	On-the-Job
a. Radiation Physics and Instrumentation					
b. Radiation Protection					
c. Mathematics Pertaining to the Use and Measurement of Radioactivity					
d. Radiation Biology					
e. Nuclear Regulations					
f. and Licensing					

2. EXPERIENCE WITH RADIATION AND RADIOACTIVE MATERIAL

Isotope	Maximum Amount	Where Experience Was Gained	Duration of Experience	Type of Use

3. EXPERIENCE WITH RADIOTHERAPY EQUIPMENT, SURVEY INSTRUMENTS AND MONITORING DEVICES

Equipment (Brand Name, Model/Serial Numbers)	Radioactive Source (Element & Mass No.)	Activity of the Source (Becquerels)	Where Experience was Gained	Duration of Experience

4. RELEVANT TRAININGS (Submit certificates of relevant trainings.)

Title of Training	Place of Training	Date of Training

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

 Signature of Proposed RSO

 Date

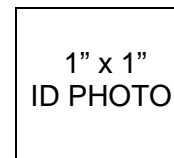
Endorsed by: _____
 Chairman, Radiation Safety Committee

Date: _____

ATTACHMENT D

**TRAINING AND EXPERIENCE OF
 PROPOSED RADIOTHERAPY TECHNOLOGIST**

NAME : _____
NAME OF INSTITUTION: _____
EDUCATIONAL DEGREE: _____



1. TRAINING RECEIVED IN BASIC RADIATION SAFETY

(Enclose certificates of training and use additional sheets if necessary.)

Field of Training	Location of Training	Date of Training	Duration of Training (Hours)		
			Lecture	Laboratory	On-the-Job
Radiation Physics & Instrumentation					
Radiation Safety & Protection					
Radiation Detection & Measurement					
Radiation Biology					

2. EXPERIENCE IN THE OPERATION OF A BRACHYTHERAPY UNIT

Equipment (Brand Name, Model/Serial Numbers)	Radioactive Source (Element & Mass No.)	Activity of the Source (Becquerels)	Where Experience was Gained	Duration of Experience (Months)

3. RELEVANT TRAININGS (Submit certificates of relevant trainings.)

Title of Training	Place of Training	Date of Training

**I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT TO
 THE BEST OF MY KNOWLEDGE.**

Signature of Radiotherapy Technologist

 Date

Endorsed by: _____

Chairman, Radiation Safety Committee

Date: _____