

## NUCLEAR MEDICINE TECHNOLOGY CERTIFICATE APPLICATION INSTRUCTIONS

The State of California is charged (Health and Safety Code, Division 20, Section 107175) with the responsibility of evaluating the qualifications of individuals performing nuclear medicine technology as described in Section 107150 of Division 20 of the Health and Safety Code. This application form is designed to assist the State in evaluating your competency to perform nuclear medicine technology (California Code of Regulations, Title 17, Section 30520) and your need for examination pursuant to Section 30532 of the California Code of Regulations, Title 17.

The bold headings below refer to sections of the application. Please submit the information requested under each section as applicable. All sections **MUST** be completed. Failure to complete part of one or more sections may lengthen the certification application process by four to six weeks.

Sections that do not apply should be marked “Not Applicable” or “N/A.”

**Name, address, etc.:** Self-explanatory.

**Scope of certificate requested:** Self-explanatory.

### **National Certification in Nuclear Medicine Technology**

Check (✓) applicable box (es). Submit documentary evidence that you have passed the examination(s) to qualify for the national certificate(s) checked. Applicants, who document passing one or more of the examinations listed on the application, are exempt from taking the state examination in nuclear medicine technology.

### **Examination**

For those candidates who must take the state-administered examination, indicate examination site and month of your choice. A current state-administered examination schedule for Northern California and Southern California is included with this application packet. Applications must be received at least 45 days prior to the requested examination date. Upon receipt, your application will be reviewed and you will be contacted regarding the time and place for the examination.

**Education:** Self-explanatory.

### **Basic Education**

Indicate the hours of instruction for each of the 20 subjects listed (indicate if the number of hours you listed is in semester or quarter hours credits where appropriate). List other basic instruction(s) in nuclear medicine technology such as continuing education, which may qualify as college level instruction.

### **Laboratory Experience**

Indicate the hours of instruction for each of the seven subjects listed. List other laboratory experiences such as wipe test for removable contamination or quality control of dose calibrator.

**Equipment Used:** Self-explanatory.

### **Clinical Experience**

A. In Vitro Tests: Self-explanatory.

B. In Vivo Nonimaging Tests Involving Measurement of Uptake, Dilution, Absorption, and Excretion.

Under “procedures you have performed,” you should indicate red blood cell volume studies under “RBC” and plasma volume studies performed under “blood/plasma volume.”

C. Imaging Studies: Self-explanatory.

D. Administration of Radioactive Material for Diagnostic Purposes:

**Do not fail to indicate the number of IV administrations you have performed.**

E. Withdrawal of Blood Samples for In Vitro Tests: Self-explanatory.

F. Administration of Radioactive Material for Therapeutic Purposes: Self-explanatory.

**Use of Generators and Reagent Kits for Preparation of Radiopharmaceuticals (Radioactive Material):**  
Self-explanatory.

**Check list of items to be submitted with your completed application:**

Item 1 Completion document from your nuclear medicine technology program and/or a transcript of courses taken and program completion date.

Items 2 and 3 Self-explanatory.

Items 4–8 Enclose a letter from your supervising radiologist or chief technologist verifying that you have been employed as a nuclear medicine technologist (8), have performed the procedures marked on your application (4) and have performed at least the required minimum number of procedures as outlined in questions 5, 6, and 7 of this section **OR**

**If you have recently completed a nuclear medicine technologist training program** from a JRCPNMT-accredited program, please obtain a letter from the director of your program verifying that you have performed the procedures marked on your application (4) and have performed the required minimum number of procedures as outlined in questions 5, 6, and 7 of this section.

Item 9 Submit the nonrefundable **CDPH-RHB application fee** of \$153.00 in the form of a check or money order made payable to **CDPH-RHB**, (the California Department of Public Health-Radiologic Health Branch).

**Declaration: Do not forget to sign and date your application form.**

## NUCLEAR MEDICINE TECHNOLOGY CERTIFICATE APPLICATION

Please READ the instructions before completing this form. Read Privacy Notification on page 4.

Name (last)	(first)	(middle)	Date of birth	Gender	
				<input type="checkbox"/> Male	<input type="checkbox"/> Female
Mailing address (number, street, P.O. Box)			City	State	ZIP code
Home telephone number ( )			Work telephone number ( )		
Presently employed as: <input type="checkbox"/> Nuclear Medicine Technologist <input type="checkbox"/> Other (specify) _____					
Name of present employer				Social security number	
Address of present employer (number, street)			City	State	ZIP code
Telephone number ( )	FAX number ( )		E-mail address		

**NOTE: You may submit your P.O. BOX number rather than your home address if no other business address is available.**

### Scope of Certificate

- Diagnostic in vivo and in vitro tests involving measurement of uptake, dilution, or excretion, including venipuncture, but not involving imaging.
- Use of generators and reagent kits for preparation of radioactive material.
- Diagnostic nuclear medicine technology procedures involving imaging, including venipuncture.
- Internal radioactive material therapy.

### National Certification in Nuclear Medicine Technology

<input type="checkbox"/> ARRT	Year examination taken: _____	<input type="checkbox"/> ASCP	Year examination taken: _____
<input type="checkbox"/> NMTCB	Year examination taken: _____	<input type="checkbox"/> Other (specify): _____	

### Examination

If required, I prefer to take the examination in  Southern California  Northern California In the month of: \_\_\_\_\_

### Education

Indicate the highest grade you have completed: \_\_\_\_\_

Name of college or university attended	Location of college or university attended			
<b>Course of Study</b>	<b>Units Completed</b>		Degree	Graduation Date
	Quarter	Semester		

Name of nuclear medicine technology school	Location		
Date attended		Total length of the course (in months)	
From: _____	To: _____		

Additional nuclear medicine education and training:

**Basic Education**

Subjects	Hours of Instruction	Subjects	Hours of Instruction
1. Human anatomy and physiology		12. Nuclear instrumentation	
2. Physics		13. Statistics	
3. College mathematics		14. Radionuclide chemistry	
4. Medical terminology		15. Radiopharmacology	
5. Oral and written communication		16. Department organization and function	
6. General chemistry		17. Radiation biology	
7. Medical ethics		18. Nuclear medicine technology	
8. Methods of patient care/nursing		a. In vivo procedures	
9. Radiation safety and protection		b. In vitro procedures	
10. Nuclear medicine physics		19. Radionuclide therapy	
11. Radiation physics		20. Computer applications	

List any other basic instruction in nuclear medicine technology (indicate subjects and total hours per subject)

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**Laboratory Experience**

Subjects	Hours of Instruction	Subjects	Hours of Instruction
1. Collimators—sensitivity versus resolution		8.	
2. Survey instruments—calibration and use		9.	
3. Gamma ray spectrometry		10.	
4. Nuclear generators and dose calibration		11.	
5. Preparation of radioactive material		12.	
6. In vitro laboratory		13.	
7. Radioactive waste handling techniques		14.	

**Equipment Used**

Survey meters:       GM       Ion chamber       Other (specify) \_\_\_\_\_

Dose calibrators:      Make and model \_\_\_\_\_

Scintillation cameras:      Year manufactured \_\_\_\_\_      Make \_\_\_\_\_

Equipped with digital system

Well counter:      Type \_\_\_\_\_      Make \_\_\_\_\_

Multi-channel analyzers

Ergometers:      Type \_\_\_\_\_      Make \_\_\_\_\_

Treadmill:      Type \_\_\_\_\_      Make \_\_\_\_\_

Lung ventilation:      Type \_\_\_\_\_

Thrombosis detection system:      Type \_\_\_\_\_      Make \_\_\_\_\_

Other (specify) \_\_\_\_\_

**Clinical Experience**

**A. In Vitro Tests**— Indicate type and number of in vitro tests you have performed:

Type of In Vitro Test	Number Performed	Type of In Vitro Test	Number Performed
_____	_____	_____	_____
_____	_____	_____	_____

**B. In Vivo Nonimaging Tests Involving Measurement of Uptake, Dilution, Absorption, and Excretion**

Indicate radioisotopes you have used:

- Cobalt 57     Cobalt 58     Iodine 123     Iodine 125     Iodine 131  
 Iron 59     Xenon 133     Chromium 51     Other (identify) \_\_\_\_\_

Indicate procedures you have performed and the number performed:

Procedure	Number Performed	Procedure	Number Performed
<input type="checkbox"/> RBC	_____	<input type="checkbox"/> Iron turnover and distribution	_____
<input type="checkbox"/> GI protein loss	_____	<input type="checkbox"/> Thyroid uptake	_____
<input type="checkbox"/> B12 absorption	_____	<input type="checkbox"/> Kidney function	_____
<input type="checkbox"/> RBC survival/sequestration	_____	<input type="checkbox"/> Other (specify) _____	_____
<input type="checkbox"/> Blood/plasma volume	_____		

**C. Imaging Studies**

Indicate radioisotopes you have used for imaging purposes:

- Gallium 67     Indium 111     Iodine 123     Iodine 125  
 Krypton 81m     Technetium 99m     Thallium 201     Xenon 127  
 Other (specify) \_\_\_\_\_

Indicate imaging procedures you have performed and the number performed:

Procedure	Number Performed	Procedure	Number Performed	Procedure	Number performed
<input type="checkbox"/> Cardiac	_____	<input type="checkbox"/> Myocardial perfusion	_____	<input type="checkbox"/> Myocardial PYP infarc	_____
<input type="checkbox"/> Pulmonary	_____	<input type="checkbox"/> Pulmonary ventilation	_____	<input type="checkbox"/> CNS shunt	_____
<input type="checkbox"/> Brain	_____	<input type="checkbox"/> CNS Cisternography	_____	<input type="checkbox"/> Cystography	_____
<input type="checkbox"/> Bone	_____	<input type="checkbox"/> Bone marrow	_____	<input type="checkbox"/> Meckel's diverticulum	_____
<input type="checkbox"/> Renal	_____	<input type="checkbox"/> Renal perfusion	_____	<input type="checkbox"/> Salivary gland	_____
<input type="checkbox"/> Biliary	_____	<input type="checkbox"/> Gastric emptying	_____	<input type="checkbox"/> Tumor abscess	_____
<input type="checkbox"/> Spleen	_____	<input type="checkbox"/> LeVeen shunt patency	_____		
<input type="checkbox"/> Thyroid	_____	<input type="checkbox"/> Lymphatic system	_____		
<input type="checkbox"/> Other (specify) _____	_____	<input type="checkbox"/> Venography	_____		

**D. Administration of Radioactive Material for Diagnostic Purposes**

Indicate approximate number of IV administrations you have performed: \_\_\_\_\_

Indicate instruction you have received:

Subject	Hours of Instruction	Subject	Hours of Instruction
1. Pertinent anatomy and physiology of all possible venipuncture sites	_____	6. Postpuncture care	_____
2. Choice of instruments, IV solutions, and Equipment	_____	7. Composition and purpose of antianaphylaxis tray	_____
3. Proper puncture techniques	_____	8. First aid	_____
4. Techniques of intravenous line establishment	_____	9. Care of specimens	_____
5. Hazards and complication of venipuncture	_____	10. Basic cardiopulmonary resuscitation	_____
		11. Other (specify)	_____

**E. Withdrawal of Blood Samples for In Vitro Tests**

Indicate approximately the number of withdrawals of blood samples you have performed in the past five years: \_\_\_\_\_

**F. Administration of Radioactive Material for Therapeutic Purposes**

Number of Treatments		Number of Treatments	
<input type="checkbox"/> Iodine 131	_____	<input type="checkbox"/> Samarium 153	_____
<input type="checkbox"/> Phosphorus 32	_____	<input type="checkbox"/> Other (specify) _____	_____
<input type="checkbox"/> Strontium 89	_____		

**USE OF GENERATORS AND REAGENT KITS FOR PREPARATION OF RADIOPHARMACEUTICALS (RADIOACTIVE MATERIAL)**

Indicate type of generators and reagent kits you have used:

Molybdenum 99/technetium 99m                       Rubidium/krypton 81m

Other (specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please submit the following documents.**

- 1. Copy of your graduation diploma and school transcripts.
- 2. Copy of your national certificate(s) in nuclear medicine technology.
- 3. Verification of date you passed national certification examination in nuclear medicine technology.
- 4. Verification that you have performed nuclear medicine technology procedures marked on the application.
- 5. Verification that you have been trained and have performed at least ten administrations of radioactive material to human beings for IN VIVO tests and/or imaging.
- 6. Verification that you have been trained and have performed at least ten withdrawals of blood for IN VITRO studies.
- 7. Verification that you have been trained and have assisted in the performance of ten oral administrations of radioactive material to human beings for therapeutic purposes under proper supervision.
- 8. Verification that you have been employed as a nuclear medicine technologist.
- 9. Nonrefundable application fee payable to the California Department of Public Health-Radiologic Health Branch (CDPH-RHB).

Please indicate other documents you are submitting with your application to support your request for certification:

\_\_\_\_\_

\_\_\_\_\_

**Declaration**

***I certify that the information provided on the application and the documents submitted with the application are true and accurate.***



\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

**Privacy Notification**

This information is requested by the California Department of Public Health, Radiologic Health Branch, and is needed to determine your qualifications for a certificate in nuclear medicine technology pursuant to Section 107155 of the Health and Safety Code. Unless otherwise noted, the information requested is mandatory. The information submitted with and on the application may be provided to federal, state, and local agencies that request it for the purpose of law enforcement. The information requested is voluntary; however, your request for a certificate in nuclear medicine technology may be disapproved if your qualification for a certificate cannot be evaluated. For information or access to your records, contact California Department of Public Health, Radiologic Health Branch, Certification Support Unit, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414; telephone (916) 327-5106; or [www.cdph.ca.gov/rhb](http://www.cdph.ca.gov/rhb)

- MAIL  Application
- Supporting documents
- Fee

TO: Accounts Receivable and Cashiering Unit  
California Department of Public Health  
Radiologic Health Branch, MS 7610  
P.O. Box 997414  
Sacramento, CA 95899-7414

CDPH-RHB Use Only	
Certificate Number:	
Class code:	
Date coded:	
Coded by:	