

CHECKLIST – FINAL IMRT AUTHORIZATION

We request you to submit this checklist along with supporting documents to:

RHBRMT@cdph.ca.gov

Date: _____ State Facility Registration Number: FAC _____

Facility Name: _____

Physical Address: _____

Mailing Address: _____

Individual Responsible for the Facility (ex: Medical Director):

Name: _____ Title: _____

Facility Contact:

Name: _____ Title: _____

Phone: _____ Email: _____

Machine Make and Model: _____ Serial Number: _____

Room (Vault) Name/Number: _____

FINAL IMRT AUTHORIZATION REPORT

____ Copy of your RHB approved Authorization to Treat.

____ Physical address and room number where the equipment is installed match the most recently RHB approved Authorization to Treat.

____ Unit make, model, and serial number on all documents match the most recently RHB approved Authorization to Treat.

____ 12-month area monitoring reports prepared by an independent company.

____ Facility drawings identify location of area monitors and match the most recently RHB approved shielding design.

____ Areas monitored meet permissible dose limits per the most recently RHB approved shielding design.

____ 12-month patient treatment log which includes weekly or monthly totals of:

____ Patients treated

____ Treatment fractions per patient

____ Dose delivered

____ Monitor units

____ Total weekly monitor units meet workload assumptions per most recently RHB-approved shielding design.

____ Statement, signed by an authorized representative, that area monitoring reports and treatment log meet workload assumptions per most recently RHB approved shielding design.