# IEMA-OHS OFFICE OF NUCLEAR SAFETY
# 1035 OUTER PARK DRIVE
# SPRINGFIELD, ILLINOIS 62704

## AUTHORIZED USER TRAINING AND EXPERIENCE FORM

Use this form to provide notifications under 32 Ill. Adm. Code 335.45 and documentation of training and experience for authorized users (AU's) in accordance with the following parts:

- 32 Ill. Adm. Code 335.9100, **Training for Use of Manual Brachytherapy Sources**
- 32 Ill. Adm. Code 335.9120, **Training for Ophthalmic Use of Strontium-90**

**NOTE:** This form requires the applicant to attach copies of licenses and Board certifications as applicable. Failure to properly attach these documents will result in the request being delayed or denied. See Section III. Item 5A and Appendix B of the Instructional Set 52.2 (Rev. 4, 2022) for additional information.

**Nature of Request (Amendment Request or Notification)**

32 Ill. Adm. Code 335.40 allows some board-certified physicians or those currently identified on an Agency, U.S. NRC or Agreement State license as an authorized user to begin work without first obtaining an amendment. Indicate if this form is providing notice of an AU beginning work or if the licensee wishes the Agency to evaluate and amend the license. If unsure, select *"Amendment Request"*.

☐ **Notification.** I have attached the required board-certification or radioactive material license identifying the individual in Part 2 as an authorized user for the requested use(s) and certify they meet the requirements specified in 32 Ill. Adm. Code 335.40(b) to begin work under the license. This form serves as the notification required under 32 Ill. Adm. Code 335.45.

**OR**

☐ **Amendment Request.** The individual in Part 2 is seeking authorization under the alternate (training and experience) pathway, or we have elected to apply for and receive a license amendment before permitting the individual to work under the license.

**Part 1. Licensee Information**

Provide Information on the Radioactive Materials License under which the proposed Authorized User will work.

**Licensee Name:**

**Radioactive Materials License Number: IL-**

**Part 2. Proposed Authorized User (AU) Information**

| **AU Name:** | **IDFPR Medical License Number:** |
|---|---|

**Requested Use (Mark all that apply):**

☐ Any in 32 Ill. Adm. Code 335.7010, Use of Sealed Sources for Brachytherapy

☐ 32 Ill. Adm. Code 335.7100, Strontium-90 Sources for Ophthalmic Treatments

**Part 3. Authorization Pathway**

**Part 3A. Has the Proposed AU been Listed on a Radioactive Materials License or Permit for the Requested Use?**

☐ No, the proposed AU has not been listed on a radioactive material license or broad scope permit for the requested use. Continue to Part 3B.

**OR**

*(Continued on Page 2)*

☐ Yes, a copy of the radioactive materials license or broad scope permit listing the AU for the requested use (or US NRC or Agreement State equivalent) is attached; **and**

☐ If the license or permit authorization exceeds seven years from the date of this application, submit documentation (dates, description and duration) of related continuing training and experience (See Section III. Item 5A and Appendix B of Instructional Set 52.2, Rev. 4, 2022); **and**

☐ Skip Parts 3B, 3C and 4. Complete Part 5 and Submit to IEMA-OHS.

**Part 3B. Is the Proposed AU Board Certified?**

See the US NRC Medical Toolkit for recognized board certifications and required wording on certificates.

☐ No, the proposed AU is not certified by a medical specialty board whose certification process has been recognized by the US NRC. Continue to Part 3C.

**OR**

☐ Yes, a copy of the board certification, is attached; **and**

☐ If the date of board certification exceeds seven years from the date of this application, submit documentation (dates, description and duration) of related continuing training and experience (See Section III. Item 5A and Appendix B of Instructional Set 52.2, Rev. 4, 2022); **and**

☐ Skip Part 3C. Complete Part 5 and submit to IEMA-OHS.

**Part 3C. Structured Training and Experience Pathway**

☐ Complete tables 1, 2 and 3 below, detailing training and experience; **and**

☐ If the dates indicated in the table below exceed seven years from the date of this application, submit documentation (dates, description and duration) of related continuing training and experience (See Section III. Item 5A and Appendix B of Instructional Set 52.2, Rev. 4, 2022); **and**

☐ Complete Parts 4 and 5. Submit to IEMA-OHS.

**Part 3C. Table 1 – Classroom and Laboratory Training**

| Required Training | Location(s) of Training | Clock Hours | Dates of Training |
|---|---|---|---|
| See 32 Ill. Adm. Code 335.9100(b)(1)(A) and 335.9120(b)(1) | | | |

**Part 3C. Table 2 – AU Supervised Work Experience**

This part must be certified by the AU supervising the required work experience. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

| Required Work Experience | Location(s) of Experience | Clock Hours | Dates of Experience |
|---|---|---|---|
| See 32 Ill. Adm. Code 335.9100(b)(1)(B) and 335.9120(b)(2) | | | |

☐ As the supervising authorized user, I attest that the proposed individual has satisfactorily completed the required training and supervised work experience detailed above.

| | |
|---|---|
| Printed name of supervising AU: | |
| License or Permit Number identifying the Supervising AU: | Amendment #: |

| Part 3C. Table 3 – Supervised Clinical Experience in Radiation Oncology | | |
|---|---|---|
| Required Clinical Experience | Location(s) of Experience | Dates of Experience |
| As detailed in 32 Ill. Adm. Code 335.9100(b)(2) | | |

*NOTE: The supervised clinical experience shall be obtained as part of an approved formal training program. This experience may be obtained concurrently with the supervised work experience in Table 2.*

☐ As the supervising AU, I attest that the proposed authorized user has successfully completed the training and supervised work experience detailed above.

| License or Permit Number identifying the Supervising AU: | Amendment #: |
|---|---|

Supervising AU's Signature: _____

Supervising AU's Printed Name: _____ Date: _____

## Part 4. Preceptor Attestation

This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**Preceptor Attestation is being provided by:**

☐ A preceptor authorized user who meets the requirements in 32 Ill. Adm. Code 335.9120 or 335.9160.

**OR**

☐ A preceptor authorized user who meets the requirements in 32 Ill. Adm. Code 335.9100 or 335.9160.

**OR**

☐ A residency program director representing the consensus of a residency program which meets the requirements in 32 Ill. Adm. Code 335.9100(b)(3)(B).

**Preceptor Certification (Select ONE and Certify):**

I attest that the proposed authorized user listed on this form has satisfactorily completed the:

☐ 200 hours of classroom and laboratory training, 500 hours of work experience and 3 years of supervised clinical experience in radiation oncology under a qualified AU as required by 32 Ill. Adm. Code 335.9100(b), and is able to independently fulfill the radiation safety-related duties as an authorized user for manual brachytherapy sources.

**OR**

☐ 24 hours of classroom and laboratory training, including the clinical training in ophthalmic radiation therapy under a qualified AU, required by 32 Ill. Adm. Code 335.9120(b), and is able to independently fulfill the radiation safety-related duties as an authorized user of strontium-90 for ophthalmic use.

Preceptor Signature: _____ Title: _____

Preceptor Printed Name: _____ Date: _____

Preceptor Telephone: _____ Email: _____

**Part 5. Requesting Licensee's Certification:**

As a member of management or as the radiation safety officer, I am authorized to act on behalf of the licensee. I have completed the appropriate section of this form and certify that all information contained herein, including any supplements attached hereto, is true and correct to the best of my knowledge. I hereby request the above changes to our Illinois Radioactive Material License.

Signature: _____ Title: _____

Printed Name: _____ Date: _____

**Signed and completed forms may be submitted electronically with required attachments to Ema.speclic@Illinois.gov**