Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street, Des Moines, IA 50319

COMPLETION OF LIMITED RADIOGRAPHY CLINICAL TRAINING AND STATEMENT OF COMPETENCY

Trainee:____(print name)

As clinical instructor for the above individual, I verify that this individual has:

1. Demonstrated good patient care.
2. Demonstrated appropriate radiation protection for self, staff, and patient.
3. A clinical program that included:
   a. Equipment maintenance, exposures and positioning, image processing, image evaluation for quality (*Check the following applicable categories*):
      [ ] Competency in PA and Lateral chest procedures
      [ ] Competency in upper extremities procedures
      [ ] Competency in lower extremities procedures
      [ ] Competency in spinal procedures
      [ ] Competency in shoulder procedures
      [ ] Competency in additional pediatric procedures
4. Direct supervision by me for all practices and competencies
5. Has satisfactorily completed the required competencies with 100% accuracy.

I verify that the above individual is competent to perform radiography in the above checked areas according to the Bureau of Radiological Health's requirements. I have records of the clinical competencies on file at my facility for review. I grant permission for a representative of IDPH to comprehensively evaluate whether the above individual meets the IDPH training standards

____
Clinical Instructor Name (printed)

____ _________________________
Clinical Instructor Signature Date

____
Address

____
Phone Number

____
Email Address

You may fax or email this form to: Matthew J. Millard, MSTD, RT(R)(CT) at 515-281-4529 or matthew.millard@idph.iowa.gov