



**DEPARTMENT OF STATE HEALTH SERVICES**  
**Radiation Safety Licensing Branch**  
**Application for Mammography Certification**

Complete this application, use supplemental sheets as necessary. New facilities, submit the appropriate fee(s) and the BRC Form 226-1. Submit application to either address. Retain a copy of the application for your files.

**Postal service address:**

Department of State Health Services  
 Radiation Safety Licensing Branch  
 Mammography Certification Program  
 P.O. Box 149200  
 Austin, Texas 78756-3189

**Overnight/express service address:**

Department of State Health Services  
 Radiation Safety Licensing Branch  
 Mammography Certification Program  
 8407 Wall Street  
 Austin, Texas 78754

If there are any questions, contact the Mammography Certification Program at (512) 834-6688.

**Section 1: Facility Information**

Mammography Certification Number: \_\_\_\_\_

MQSA Facility Identification Number: \_\_\_\_\_

Legal Name of Facility: \_\_\_\_\_

DBA(if applicable): \_\_\_\_\_

County \_\_\_\_\_

Mailing Address: (Street/City/State/Zip)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Machine Use Location Address: (Street/City/State/Zip)

(If multiple use locations, use additional sheets)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Lead Interpreting Physician: \_\_\_\_\_

Radiation Safety Officer (RSO): \_\_\_\_\_

Attach qualifications as required in 25 TAC § 289.226(w)(1).

Telephone No.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Contact Person & Title: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Check one     New Facility                       New Site                       New equipment

Total number of machines at this site:

Mammography units: \_\_\_\_\_ Stereotactic Biopsy units: \_\_\_\_\_

**Section 2: Personnel Qualifications**

Complete this section for all new personnel

- List all mammography personnel.
- Fill out the “acceptable documents” forms and submit the required documentation in accordance with §289.230(f).
- Make copies of this form as needed

**Interpreting Physician(s):**

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**Radiologic Technologist(s)**

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**Medical Physicist(s):**

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| <b>Section 3: Equipment Information</b> |
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Complete this section for each mammographic x-ray unit, including breast biopsy and invasive interventions for localization.

**Include a copy of a current medical physicist's survey report for each machine.**

1. New Facilities/Sites or New Equipment:
  - a. MP survey report must be dated within the past 6 months.

Note – if there are any failures and/or deficiencies on the report, attach a list of corrective actions. Include copies of service/work invoices with the description of corrective actions.

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Site number and location of equipment: \_\_\_\_\_

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Indicate which service this unit is used for

Mammography

Breast Biopsy

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|    |                             |                                       |                             |
|----|-----------------------------|---------------------------------------|-----------------------------|
| 1. | Control Panel Manufacturer: | Control Panel Model Name<br>& Number: | Control Panel Serial Number |
|    | _____                       | _____                                 | _____                       |

|    |                         |                                      |                                  |
|----|-------------------------|--------------------------------------|----------------------------------|
| 2. | Type of Imaging System: | <input type="checkbox"/> Screen/Film | <input type="checkbox"/> Digital |
|----|-------------------------|--------------------------------------|----------------------------------|

|    |           |                                 |                                 |
|----|-----------|---------------------------------|---------------------------------|
| 3. | Location: | <input type="checkbox"/> Onsite | <input type="checkbox"/> Mobile |
|----|-----------|---------------------------------|---------------------------------|

For **Digital** units, provide which version of the quality control manual you are utilizing along with the revision number and date:

|                 |                  |            |
|-----------------|------------------|------------|
| Version # _____ | Revision # _____ | Date _____ |
|-----------------|------------------|------------|

|  |
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| <b>Section 4: Accreditation Status</b> |
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|    |                     |                                |  |
|----|---------------------|--------------------------------|--|
| 1. | Accreditation Body: | <input type="checkbox"/> Texas | <input type="checkbox"/> American College of Radiology |
|----|---------------------|--------------------------------|--|

2. If you select **American College of Radiology (ACR)**, submit a copy of the application submitted to ACR.

3. If you select Texas, request an accreditation application.

**Section 5: Mobile Services**

For mobile mammography equipment, complete this section.  
{25 TAC§289.230(l)(8)}

Main location where machine and records. will be maintained for inspection. This must be a street address.

\_\_\_\_\_  
Street City State Zip

**Attach** a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

**Section 6: Self-referral Authorization**

*Self-referral is site based.. All sites must have authorization from the Department prior to performing self-referred mammograms.*

Submit the following information if you wish to conduct self-referral mammography

Number of views for a typical mammogram? \_\_\_\_\_

Type of views for a typical mammogram? \_\_\_\_\_

- the age range of the population to be examined and the frequency of the exam following established, nationally recognized criteria of the American Cancer Society, American College of Radiology, the National Council on Radiation Protection and Measurements.
- written procedures for advising individuals and their private physicians of the results of the self-referred exam and any further medical needs indicated Include a method of follow-up to confirm that patients with positive findings, as well as practitioners, have received proper notification.
- description of the methods used to educate patients in self-examination techniques, and on the necessity for follow-up by a physician.
- film retention policy.

**Section 7: Medical Records Retention Policy**

Submit to the Department procedures for disposition/retention of medical records including films in the event of termination, failure to renew, or bankruptcy.

## Section 8: Signatures

I certify that all information submitted with this application is true and current to the best of my knowledge.

\_\_\_\_\_  
Typed or printed name of person who completed application

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Typed or printed name and title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.*

As the **lead interpreting physician**, I do hereby affirm that I assume the responsibilities in 25 TAC §289.230(k)(1)(A) in association with this application.

\_\_\_\_\_  
Typed or printed name of lead interpreting physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

As RSO for this facility, I do assume those duties and responsibilities as listed in 25 TAC 289.226(w)(2). I certify that all information submitted with this amendment is true and current to the best of my knowledge.

\_\_\_\_\_  
Typed or printed name of RSO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.tdh.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)