



Medical Radiation Technologists Board of Queensland
Supervised Practice Program Committee

FINAL REPORT FORM 701C
SECTION 61, MEDICAL RADIATION TECHNOLOGISTS ACT 2001

FINAL REPORT FORM

RADIATION THERAPY

Name of probationary registrant:

Registration number:

Name of supervisor or SPP coordinator:.....

Registration number:

Professional setting or whole of practice:.....

Address:

.....

Commencement date of SPP:.....

ABSENCE FROM WORKPLACE

Graduate	Actual Start Date	Sick Leave (days)	Annual Leave (days)	Bereavement Leave (days)	Finish Date

Is **probationary registrant** working at practice part time yes no

If yes please attach details of hours worked per week





ASSESSMENT RATINGS

IF COMPETENCIES/PROCEDURES ARE GAINED THROUGH OFF SITE VISITS NOMINATED IN THE INDIVIDUAL SITE PROGRAM, PLEASE ATTACH A LETTER FROM THE DESIGNATED SUPERVISOR AT THE OFF SITE PRACTICE DETAILING TIME SPENT AND COMPETENCIES ACHIEVED

CORE COMPETENCIES

C COMPETENT

N/C NOT COMPETENT - if the probationary registrant is not competent in any area attach detailed explanation

SPECIALISED PROCEDURES

O OBSERVE

The probationary registrant must have attended a procedure a number of times to observe, and gain knowledge and an understanding of the procedure. This observation period shall be determined by supervisor.

A ASSIST

The probationary registrant must have attended a procedure and participate in this procedure, under direct supervision, to gain knowledge and understanding as determined by the primary supervisor.



CLINICAL SKILLS ASSESSMENT

SIMULATION / CT / MOULD ROOM

RATING: **C** = COMPETENT **N/C** = NOT COMPETENT

Daily calibration and machine runup checks _____

Positions patient appropriately _____

Anticipates sequence of procedure _____

Operates equipment efficiently _____

Correlates information accurately _____

Performs routine procedures:

Single field photon (any site) _____

Opposed pair photon (any site) _____

Best contact single field electron _____

Comprehends principles, procedures and requirements to complete SIM/CT of four (4) or less fields for various sites:

Lung, oesophagus, abdomen and pelvis _____

Breast and chestwall tangentials (with or without shoulder field) _____

2- 3 FLD head and neck (parotid etc.) _____

Assists and/or performs advanced procedures in one or more of the following:

Multifield / multiphase breast (tangentials, supraclavica, axilla) _____

Multifield / multiphase head and neck _____

Multifield / multiphase pelvis _____

Multifield / multiphase (five (5) or more fields) to any site _____

Assist / perform in production of stabilisation and ancillary devices _____

Assist / perform in mould room activities _____



DOSIMETRY

RATING: **C** = COMPETENT **N/C** = NOT COMPETENT

Accurate translation of oncologist prescription and instructions _____

Ability to perform manual dose calculations _____

Proficient in use of 3D computer planning systems:

Demonstrates appropriate plan optimisation knowledge _____

Displays awareness of appropriate presentation of data required for quality assurance measures associated with plan completion _____

Ability to perform image/data transfers with awareness of workflow requirements _____

Treatment sheet production (well organised and accurate) _____

Ability to perform dosimetry on routine procedures :

Single field photon (any site) _____

Opposed pair photon (any site) _____

Best contact single field electron _____

Comprehends principles, procedures & requirements to accurately treat four (4) or less fields, for various sites:

Lung, oesophagus, abdomen and pelvis _____

Breast and chestwall tangentials (with or without shoulder field) _____

2- 3 FLD head and neck (parotid etc.) _____

Ability to perform and/or understand underlying principles of dosimetry for advanced procedures : (one or more of the following approaches)

Multifield / multiphase breast (tangentials, supraclavicular, axilla) _____

Multifield / multiphase head & neck _____

Multifield / multiphase pelvis _____

Multifield / multiphase five (5) to any site _____

A required minimum of 20 weeks full time equivalent in the treatment section by the time of the final report.



TREATMENT

RATING: **C** = COMPETENT **N/C** = NOT COMPETENT

Daily calibration checks _____

Positions patient appropriately _____

Anticipates sequence of procedure _____

Awareness of patient management issues at the treatment console _____

Operates equipment efficiently _____

Adopts workplace safety practices _____

Demonstrates understanding of quality assurance processes of the work area _____

Ability to perform routine procedures :

Single field photon (any site) _____

Opposed pair photon (any site) _____

Best contact single field electron _____

Comprehends principles, procedures & requirements to accurately treat 4 or less fields, for various sites :

Lung, oesophagus, abdomen & pelvis _____

Breast and chestwall tangentials (with or without shoulder field) _____

2 - 3 FLD head and neck (parotid etc.) _____

Ability to perform and/or understand underlying principles of advanced procedures :

(One or more of the following approaches).

Multifield / multiphase breast (tangentials, supraclavicular, axilla) _____

Multifield / multiphase head & neck _____

Multifield / multiphase pelvis _____

Multifield / multiphase (five (5) or more fields) to any site _____

A required minimum of 20 weeks full time equivalent in the treatment section by the time of the final report.



ASSIST / OBSERVATION OF SPECIALISED PROCEDURES

If available at a clinical setting: (Not Mandatory)

Stereotactic radiosurgery _____	<input type="text"/>
Total body irradiation _____	<input type="text"/>
Orthovoltage therapy _____	<input type="text"/>
Superficial therapy _____	<input type="text"/>
HDR/LDR Brachytherapy _____	<input type="text"/>

PERSONAL /PROFESSIONAL ATTRIBUTES

RATING: **C = COMPETENT** **N/C = NOT COMPETENT**

PATIENT CARE

Please take into account attributes such as correct identification, monitoring of the patient, empathy and awareness of patient needs, consideration of patient confidentiality, effective communication and cultural awareness.

Rating: Comments:

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TEAM WORK

Please take into account attributes such as understanding of the role of a multidisciplinary team, recognition of limitations and willingness to seek assistance when appropriate, ability and willingness to accept direction and effective communication with the health care team.

Rating: Comments:

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SAFETY

Please take into account attributes such as awareness of a safe working environment for patients and staff, demonstrated knowledge of universal precautions, awareness and application of the local radiation protection plan.

Rating: Comments:

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.....

CODES OF PRACTICE

Please take into account attributes such as awareness of and compliance with local and national codes of practice and ethics

Rating: Comments:

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CONSISTENCY OF PRACTICE

Consistency of practice and competency levels in all work areas throughout the period of the final report. Please note the circumstances leading to inconsistent practice.

Rating: Comments :.....
.....
.....

PROFESSIONAL DEVELOPMENT

ANY ONE OF THE ACTIVITIES INVOLVING IN-SERVICE, SKILLS DEVELOPMENT AND SEMINARS ATTENDED DURING THE PERIOD BETWEEN THE PROGRESS AND FINAL REPORT.

When
Where
Topic

IF INSUFFICIENT SPACE PLEASE ATTACH AS A DOCUMENT

CASE STUDY/ PRESENTATION BY PROBATIONARY REGISTRANT

When
Where
Topic presented
To whom

A MINIMUM OF ONE CASE STUDY/ PRESENTATION IS REQUIRED BY THE FINAL REPORT.

THE BOARD MAY AUDIT THE PROFESSIONAL DEVELOPMENT PROGRAM FOR PROBATIONARY REGISTRANT. DOCUMENTS VALIDATING PARTICIPATION WILL BE REQUIRED ON REQUEST.

COMMENTS

COMMENTS, PRIMARY SUPERVISORS / SPP COORDINATORS - AS NOMINATED ON SUPERVISED PROFESSIONAL PRACTICE SETTING NOTIFICATION FORM (FORM NUMBER 501A)

Please comment on the progress and competence of the probationary registrant at this stage of the supervised practice program.

.....
.....
.....

SIGNATURE:..... NAME:.....

DATE:



PROBATIONARY REGISTRANT COMMENTS

.....
.....
.....
.....

SIGNATURE:..... NAME:.....

DATE:

PROVIDE ATTACHMENTS OF THE FOLLOWING IF APPLICABLE AT THIS TIME:

1. OFF SITE VISIT VERIFICATION
2. IN-SERVICE ATTENDANCE
3. PART-TIME HOURS WORKED

NOTICE OF COMPLETION OF SUPERVISED PRACTICE PROGRAM

Section 93 Medical Radiation Technologists Registration Act 2001

I have completed my supervised practice program and request that the probationary conditions be removed from my general registration.

SIGNED:.....

DATE:

Scan and email to mrt@healthregboards.qld.gov.au

Please also send the original signed documents to:

**MRTBQ
GPO Box 2438
Brisbane Q 4001**





SURNAME..... DATE OF BIRTH.....

Please Print

GIVEN NAMES.....

TITLE: Mr, Mrs, Miss, Ms, Other.....

ADDRESS

.....

NAME OF ACADEMIC INSTITUTION ATTENDED:.....

NAME OF QUALIFICATION OBTAINED.....

YEAR OBTAINED.....

INTERNATIONAL STUDENTS SEEKING A VALIDATED STATEMENT OF ACCREDITATION

MUST SUBMIT WITH APPLICATION EVIDENCE OF UNDERSTANDING AND FLUENCY IN ENGLISH.

EITHER OF THE FOLLOWING IS REQUIRED AS EVIDENCE:

- OVERALL BAND SCORE OF NOT LESS THAN 7 ACADEMIC IN THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS)
- OR
- OVERALL MINIMUM OF LEVEL B RESULT IN THE AUSTRALIAN OCCUPATIONAL ENGLISH TEST (OET)

I declare that the information I have supplied in this application and attached (if applicable) is complete, correct, and up to date in every detail. I understand that if I give false or misleading information, my application may be refused.

I understand the validated Statement of Accreditation I am applying for is valid for a three year period after which time a further validated Statement of Accreditation will be issued on evidence of Continuing Professional Development (CPD)

SIGNATURE OF APPLICANT:

DATE:.....

Application must be validated by the Secretary or nominee of the relevant State PAEC in which the applicant is employed to indicate that the PDY/Internship has been completed satisfactorily.

VALIDATION BY STATE PAEC

This is to certify that.....

Applicants Name.

Has satisfactorily completed all requirement and is recommended for the issue of:

VALIDATED STATEMENT OF ACCREDITATION

Date Recommended:..... Diagnostic

Therapy

State/Territory where PDY completed:

Signed: Date:.....

Secretary - State PAEC or nominee



THIS SECTION TO BE MAILED BY THE APPLICANT WITH REQUIRED REMITTANCE TO:

EXECUTIVE OFFICER

AIR

The General Secretary AIR, PO Box 1169 Collingwood Victoria Australia 3066

Surname.....Title (Mr/Mrs/Miss/Other).....

Given Names.....

Address

..... Ph. No.....

Cost: \$220 (\$200 + \$20 GST)

(Rebate of \$100 given off AIR Membership Subscription if Membership application recieved at the Secretariat within 3 months of receipt of this form & remittance)

Enclosed: Cheque Credit Card B/C VISA M/C A/MEX

Card number (0000) (0000) (0000) (0000) Expiry Date

Signature of Cardholder

Name of Cardholder (Please Print)

OFFICE USE ONLY

Accreditation No:..... Date Operative

Signed:..... Expiry Date:.....

Statement to: Applicant Other.....

Mailed:.....

Note Granted: Ref No..... Signed.....

Payment:

Date received..... Amount \$220..... Signed.....

Statement to : PAEC Applicant Other..... Mailed:.....

Not Granted: Ref No..... Signed.....