# Amendment or renewal practitioner licence application form

This is an application form to amend or renew a practitioner licence to administer radioactive substances as required under:

* Ionising Radiation (Medical Exposure) Regulations 2017
* Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018

Use this form to apply to amend or renew your practitioner licence. Application forms and any supporting information should be submitted through the [online application portal](https://digitaltools.phe.org.uk/servicedesk/customer/portal/22).   
**Please do not delete any sections of this form when completing.**

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|  | Title | Click here to enter text. |
|  | First name | Click here to enter text. |
|  | Last name | Click here to enter text. |
|  | Practitioner licence number | Click here to enter text. |

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|  | Application type  (Tick all that apply) | Remove procedure(s) | |  |
| Add procedure(s) | |  |
| Change of purpose of procedure (for example from research to routine) | |  |
| Renew licence (please fill in Q6 and Q11 to Q17) | |  |
|  | **Existing procedures** | | | |
|  | Do you wish to continue to be authorised for all current procedures on your licence? (If yes, please fill in Q11 to Q17) | | Yes / No | |
|  | If no, please list the procedure codes to be removed from your licence. | |  | |

**Additional procedures requested**

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|  | **Additional diagnostic procedures** |
|  | Please enter procedure codes for the additional procedures in the [Notes for guidance](https://www.gov.uk/government/publications/arsac-notes-for-guidance) that are required individually.  (To add more procedures, insert rows into the table and if desired copy the relevant drop down box to the new row) |
|  | Select diagnostic procedures |
|  | Select PET procedures |
|  | Click here to enter text. |

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|  | Additional functional groups – please check the relevant boxes where all the procedures within the functional group selected are required | | | | | |
|  | Imaging | | | | Non-imaging | |
| 1 – Cardiac |  | 8 – Genito-urinary |  | 20 – Absorption |  |
| 2 – Vascular |  | 9 – Infection/Inflammation |  | 22 – Haematology |  |
| 3 – Lung |  | 10 – Haematology |  | 23 – Endocrine |  |
| 4 – Brain |  | 11 – Endocrine |  | 24 – Gastrointestinal |  |
| 5 – Bone/joint |  | 13 – Lacrimal |  | 25 – Genito-urinary |  |
| 6 – Gastrointestinal |  | 14 – Tumour |  |  |  |
| 7 – Hepatobiliary |  | 15 – Sentinel node |  |  |  |

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|  | Please enter details of additional procedures requested that are not included in the ‘Notes for guidance’.  (Please enter one procedure per line, to apply for additional procedures insert more rows into the table and include any references for effective doses listed)  If you know the relevant procedure code, you can include this with the indication, but it is not mandatory. | | | | | | |
|  | Radio-nuclide | Pharmaceutical or chemical form | Indication | Route | Activity (MBq) | ED (mSv) |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

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|  | **Additional sealed source therapy**  (For those procedures in the ‘Notes for guidance’, please include the procedure code in the first column. Enter one procedure per line, to apply for additional procedures insert more rows into the table.) | | | | | |
| Procedure code | Radionuclide | Appliance or device | Indication | Number performed in last 12 months | Predicted number to be performed in next 12 months |
| Choose an item. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

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|  | **Additional unsealed source therapy** | | |
|  | Please enter procedures requested that are in the ‘Notes for guidance’.  (To apply for more than one procedure copy the block below and complete all question (i) to (viii) for each procedure) | | |
|  | Procedure code or serial number | Select a procedure code | |
|  | How is administered activity calculated? | Choose an item. | Click here to enter text. |
|  | Organ(s) at Risk (OaR) (please indicate the most relevant) | Click here to enter text. | |
|  | Maximum dose likely to be received by specified OaR | Click here to enter text. | |
|  | Method for calculation of dose to OAR and/or tumour | Choose an item. | Click here to enter text. |
|  | Details of any dose limiting measures for the patient used locally  (for example, renal protection with amino acids, or increased oral hydration) | Click here to enter text. | |
|  | Number performed in last 12 months | Click here to enter text. | |
|  | Predicted number performed in next 12 months | Click here to enter text. | |

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| 9. | **Additional unsealed source therapy** | | |
| b. | Please enter procedures requested that are notin the ‘Notes for guidance’.  (To apply for more than one procedure copy the block below and complete all question (i) to (xi) for each procedure) | | |
|  | Radionuclide | Click here to enter text. | |
|  | Pharmaceutical or chemical form | Click here to enter text. | |
|  | Indication | Click here to enter text. | |
|  | Route | Click here to enter text. | |
|  | How is administered activity calculated | Choose an item. | Click here to enter text. |
|  | Organ(s) at Risk (OaR) (please indicate the most relevant) | Click here to enter text. | |
|  | Maximum dose likely to be received by specified OaR | Click here to enter text. | |
|  | Details of method for calculation of dose to OAR | Choose an item. | Click here to enter text. |
|  | Details of any dose limiting measures for the patient used locally (for example, thyroid blocking) | Click here to enter text. | |
|  | Number performed in last 12 months | Click here to enter text. | |
|  | Predicted number performed in next 12 months | Click here to enter text. | |

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|  | **Additional research** | | | | | | | |
|  | Would you like to apply to administer all diagnostic procedures listed in Q7 for research? | | | | | Choose an item. | | |
|  | Would you like to apply to administer all sealed source therapy procedures listed in Q8 for research? | | | | | Choose an item. | | |
|  | Would you like to apply to administer all unsealed source therapy procedures listed in Q9 for research? | | | | | Choose an item. | | |
|  | Please enter details of any additional procedures requested for research that are not included in a, b or c above.  Please enter one per line and include references for effective doses. To add more procedures, insert additional rows into the table.  If you know the IRAS ID for the relevant study, you can include this under ‘Indication’, but it is not mandatory. | | | | | | | |
| Procedure code | Radionuclide | Pharmaceutical or chemical form | Indication | Route | | Activity (MBq) | ED (mSv) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. |

**Training and experience**

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|  | Have you undertaken appropriate continuing medical education and maintained your competence as a practitioner in all current procedures on your licence since your last application? | | Yes / No |
|  | If no, please provide details | | Click here to enter text. |
|  | Are all the additional procedures requested within the scope of your existing theoretical training? | | Yes / No |
|  | Please provide details of any relevant theoretical training undertaken for the procedures requested.  (Please enter one type of training per block, you can add multiple blocks. Certificates for courses attended can be attached when submitting on the portal) | | |
|  | Type of training | Choose an item. Click here to enter text. | |
|  | Scope | Click here to enter text. | |
|  | Procedures | Click here to enter text. | |
|  | Dates of training | Click here to enter text. | |
|  | Institution | Click here to enter text. | |

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|  | Please provide details of all relevant practical training and experience for the requested procedures. Experience in similar procedures can be included as evidence where skills are translatable.  (Please enter one type per block, you can add multiple blocks) | |
|  | Type | Choose an item. Click here to enter text. |
|  | Procedures | Click here to enter text. |
|  | Dates | Click here to enter text. |
|  | Institution | Click here to enter text. |
|  | Supervisor, training lead or mentor  (if applicable) | Click here to enter text. |
|  | Approximate numbers of cases | Click here to enter text. |
|  | Details | Click here to enter text. |

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|  | Medical radiological installations where you are (or will be) entitled as an IR(ME)R practitioner | |
|  | Do you support more than one site/installation? | Yes/No |
|  | If yes to 15a), please list the sites and include details of the number of sessions of support for each site.  Please provide details of how you supervise each of the services. | Click here to enter text. |
|  | If you support more than one site, please provide details of how you supervise each of the services. Please include details of the number of sessions of support for each site. | Click here to enter text. |
|  | Do you provide any support remotely? | Yes/No |
|  | If yes to 15d), please confirm for which sites remote support is provided and provide details of how this support is provided. | Click here to enter text. |

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|  | Please provide any other relevant information to support this application:   * rationale for application * supporting statement regarding new procedures   Additional attachments (for example, letters of support) can also be added to the application on the online portal when submitting. |
| Click here to enter text. |

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|  | Practitioner declaration:   * I apply for a practitioner licence to justify the procedures involving the administration of radioactive substances included in this application form. * I confirm that all information contained in this application form is correct and there are no changes to the existing information since my last full application. * I confirm that I have undertaken the continuing medical education appropriate to hold a practitioner licence. | |
| Practitioner signature (electronic signatures can be used) | Click here to enter text. |
| Date | Click here to enter a date. |