

Agenda Item 7

Enclosure 7

Paper RC 7 / 02

REGISTRATION COMMITTEE

RADIOGRAPHERS' FORMS B & C

From : Secretary to the Committee

Council for Professions Supplementary to Medicine
Radiographers Board Park House • 184 Kennington Park Road • London SE11 4BU

To be completed by the Institution at which the qualification was gained

Please ensure that the information on this form relates to the course which was undertaken by the applicant and not to the current course.

Complete the form in *black ink* and in *English* using *capital letters* throughout. Each page must be validated by the use of the *Institutional Seal*.

General informationName of Applicant: Address of Applicant: Name of Institution:

I certify that our records show that the above applicant attended this institution from (date) to (date) and that they completed the curriculum of study in radiography which is itemised in this form.

Please use Institution Seal below

Signature:

Position:

Date:

About the courseLength of course in years: Total number of study hours (excluding clinical hours): Total number of clinical hours: **Curriculum of study**

In the following sections we want to find out details about:

- ① The *content* of the course.
- ② The *main subject* areas covered by the applicant during their course of study.
- ③ The *total hours of teaching* devoted to these subject areas.
- ④ The *lecturers involved* in teaching the main subject areas.

Complete only those areas which were undertaken during the course by *this* applicant.

Biological Sciences

Details of Radiography Training

Note: Complete only those areas which were undertaken during the course by *this* applicant

Total allocated hours:

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Anatomy			
Physiology			

Biological Sciences continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Pathology			
Other (please state)			

Physical Sciences

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
General Physics			
Radiation Physics			
Radiotherapy Physics			

Physical Sciences continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Radiotherapy Equipment			
Radiographic Equipment			
Radiation Protection			

Physical Sciences continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Radiation Treatment Planning/ Dosimetry			
Principles of Imaging			
Equipment for Imaging			
Other (please state)			

Principles and Equipment

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
CT			
MR			
Ultra Sound			

Principles and Equipment continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Nuclear Medicine			
Other (please state)			

Behavioural Sciences

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Psychology			
Sociology			
Communications & Interpersonal Skills			

Other Studies

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician= *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Information Technology			
Health & Safety			
Law & Ethics			
Structure of Professional Organisations			

Other Studies continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Management of Services			
Research & Evaluation of Practice			
Other (please state)			

Professional Studies

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Oncology			
Radiotherapy Applications			

Professional Studies continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Radiographic Applications			
Image Interpretation			

Professional Studies continued

Please indicate whether the subjects listed below were studied. Record the name of the tutor or lecturer involved and their position using the following abbreviations:

Academic Radiographer Lecturer = *ARL*, Academic Other Disciplines = *AOD*, Radiographer Clinician = *RC*, Medical Doctor = *MD*

Subject	Summary of Content	Teaching Hours	Status of Lecturer
Patient Care			
Other (please state)			

Radiography Clinical Education & Practice

Name of Clinical Training Institution:

Address of Clinical Institution:

.....

Name of Clinical Supervisor:

Status and qualifications of Supervisor:

Summary of Clinical Education & Practice Attendance:

Period of Training	Number of weeks	Number of hours per week	Total hours per year
Year one:			
Year two:			
Year three:			
Year four:			
Total:			

Radiography Clinical Education & Practice continued

Breakdown of Clinical Education and Practice:

Radiotherapy Equipment/Area	Additional Information: Modality, Beam Energies, Radionuclide (where appropriate)	Year one weeks	Year two weeks	Year three weeks	Year four weeks	Total number of weeks
Superficial						
Orthovoltage						
Teletherapy						
Linear Accelerators						
Brachytherapy						
Treatment Simulation						
Mould Room						
Dosimetry						

Radiography Clinical Education & Practice continued

Breakdown of Clinical Education and Practice:

Radiotherapy Equipment/Area <i>Other related areas:</i>	Additional Information: Modality, Beam Energies, Radionuclide (where appropriate)	Year one weeks	Year two weeks	Year three weeks	Year four weeks	Total number of weeks
Clinics						
Hospital Wards						
Medical Records						
Nuclear Medicine						
Medical Physics						
Sealed Sources Laboratory						
Medical Imaging						
Other (please state)						
Total:						

Radiography examinations	Additional Information Modality	Year One weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Accident and Emergency						
Hospital Wards						
Medical Records						
Nuclear Medicine						
Medical Physics						
Mamography						
Medical Ultrasound						
Other (please state)						
Total:						

Questionnaire

Radiography Clinical Education & Practice continued

Breakdown of Clinical Education and Practice:

Radiography examinations	Additional Information Modality	Year One weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Accident and Emergency						
Hospital Wards						
Medical Records						
Nuclear Medicine						
Medical Physics						
Mamography						
Medical Ultrasound						
Other (please state)						
Total:						

Breakdown of Clinical Education and Practice:

Radiography Examinations	Additional Information Modality	Year One Weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Extremities						
Chest						
Arial Skeleton						
Abdomen						
Barium Studies						
Genito-Urinary Tract						
Operating Theatre						
Mobile (Ward) Radiography						

Assessment/examination procedure

Please specify the subject, including clinical experience assessed during the applicant's course including:

1 The *method of assessment* using the following abbreviation:

- | | |
|--|--------------------------------|
| Unseen written paper A | Viva voce D |
| Written assignment B | Seminar/presentation E |
| Practical C | Other (please specify) F |
| Objective Structured Clinical Examination (OCSE) G | |

2 The *type of assessment* using the following abbreviations:

- | | |
|--|---|
| Formative or continuous assessment | F |
| Summative or formal end of year examination/assessment | S |

3 The *stage of assessment* i.e. Year one, Year two, Year three or Year four

Subjects	Method of assessment	Type of assessment	Stage of assessment

Specify the date the applicant successfully completed the course:

Name of award, if applicable:

Classification of award:

Please use the School/Institution seal:

Signature of the Course Leader/Director: Date:

Radiography examinations	Additional Information Modality	Year One weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Accident and Emergency						
Hospital Wards						
Medical Records						
Nuclear Medicine						
Medical Physics						
Mamography						
Medical Ultrasound						
Other (please state)						
Total:						

Questionnaire

Radiographers Board

Radiography Clinical Education & Practice continued

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Radiography Clinical Education & Practice continued

Breakdown of Clinical Education and Practice:

Radiography examinations	Additional Information Modality	Year One weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Accident and Emergency						
Hospital Wards						
Medical Records						
Nuclear Medicine						
Medical Physics						
Mamography						
Medical Ultrasound						
Other (please state)						
Total:						

Breakdown of Clinical Education and Practice:

Radiography Examinations	Additional Information Modality	Year One Weeks	Year Two weeks	Year Three weeks	Year Four weeks	Total Number of Weeks
Extremities						
Chest						
Aerial Skeleton						
Abdomen						
Barium Studies						
Genito-Urinary Tract						
Operating Theatre						
Mobile (Ward) Radiography						

Our ref: «Our_Ref»/«Contact_Number»/

Your ref: «Advanced_Application_Number»

Date: «Date»

XXXX
XXXX
XXXX

Dear XXXX

We have been asked by a former student of your institution, «Name» to send you a 'Confirmation of Qualification' form for you to complete and return to the above address. «Name» is applying, through us, for state registration in this country as an occupational therapist. The enclosed form is a vital piece of documentation required for the assessment of such applicants. Therefore we appreciate your assistance in this matter. The applicant should meet any costs for this service.

You may be familiar with the lengthier Questionnaire B, which this form replaces. Whereas Questionnaire B sought information on the content of your course, and the way in which the individual applicant's learning was structured, the 'Confirmation of Qualification' simply assures us of the fact that the applicant did indeed complete your course. This reduced form reflects the fact that we are familiar with the training offered in your country and do not require information to the depth we used to.

Please complete the form **in English** using black ink and block capitals. The form should also bear the institutional seal.

Thank you for your time, and if you have any further queries please contact the office on ++020 7582 0866.

Yours sincerely

«Signatory»
«Sig_Position»

Health Professions Council



Radiography Park House, 184 Kennington Park Road, London, SE11 4BU

To be completed by the Institution at which the qualification was gained.

Please ensure that the information on this form relates to the course which was undertaken by the **applicant**.

Complete the form in *black ink* and in *English* using *capital letters*. It must be validated by the use of the *Institutional Seal*.

General Information

Name of Applicant:

«Name»

Name in which the
award was obtained:
(If different)

Address of Applicant:

«Address_1», «Address_2», «Address_3», «Town», «County», «Postcode», «Country»

Name of Institution:

I certify that our records show that the above applicant attended this institution from

(date).....to (date) and that they successfully completed
the curriculum of study in radiography leading to the following qualification

Please indicate*: Diagnostic / Therapeutic / both *(Delete as appropriate)

Signature:.....

Please use Institutional Seal Below

Position:.....

Date:.....

Validated by Institution – date.....

Considered by Radiographers

Board's Registration Committee – date.....