

SOCIETY AND COLLEGE OF RADIOGRAPHERS

**APPLICATION FORM FOR ACCREDITATION & INCLUSION ON THE
VOLUNTARY REGISTER OF ASSISTANT PRACTITIONERS**

SURNAME: **TITLE:** **D.O.B.**.....

FORENAMES:

CONTACT ADDRESS:
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.....
.....

WORK TELEPHONE NO: **EMAIL:**

SOCIETY OF RADIOGRAPHERS MEMBERSHIP NO: **OR FEE ENCLOSED £**.....

QUALIFICATIONS:
.....

PRESENT POST (Please attach a current job description and KSF outline, if available)

Job Title and Grade.....

Work address.....

NAME & ADDRESS OF PREVIOUS EMPLOYER(S) NB Health Care only

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**SUMMARY DETAILS OF EDUCATION AND TRAINING RELEVANT TO CLINICAL IMAGING OR
RADIOTHERAPY (portfolios of evidence may be requested)**

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NAMES AND JOB TITLES OF PERSONS SUPPLYING REFERENCES

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.....

I wish to be considered for accreditation in the following modalities and activities (Please tick all boxes that apply):

Modality or Discipline

- | | | | |
|------------------------|--------------------------|-----------------------|--------------------------|
| Diagnostic Radiography | <input type="checkbox"/> | Radiotherapy/Oncology | <input type="checkbox"/> |
| Ultrasound | <input type="checkbox"/> | Nuclear Medicine | <input type="checkbox"/> |
| Magnetic Resonance | <input type="checkbox"/> | | |

Scope of Practice – please tick all that apply

Clinical Imaging

- | | | | |
|----------------------------------|--------------------------|-----------------------------|--------------------------|
| Plain film Appendicular Skeleton | <input type="checkbox"/> | Plain Film Chest | <input type="checkbox"/> |
| Plain film Abdomen | <input type="checkbox"/> | Plain film Spine and Pelvis | <input type="checkbox"/> |
| Mammography | <input type="checkbox"/> | Assisting in Fluoroscopy | <input type="checkbox"/> |
| Assisting in mobile radiography | <input type="checkbox"/> | Assisting in CT/MRI/NM | <input type="checkbox"/> |

Radiotherapy

- | | |
|---|--------------------------|
| Acquire images, data and reference material for radiotherapy processes | <input type="checkbox"/> |
| Perform simple treatment calculations | <input type="checkbox"/> |
| Produce a treatment isodose plan | <input type="checkbox"/> |
| Deliver external beam megavoltage radiation | <input type="checkbox"/> |
| Deliver external beam kilovoltage radiation | <input type="checkbox"/> |
| Provide care for patients before, during and following a radiotherapy visit | <input type="checkbox"/> |

Please state any other area of interest:

I agree to accept that my name, scope of practice and geographical location of my workplace will appear on the Society of Radiographers Voluntary Register. The Register can be viewed at www.sor.org

SIGNATURE: DATE:

*Please return this form to the Accreditation Department,
The College of Radiographers, 207 Providence Square, Mill Street, London, SE1 2EW*

Please check that you have included the following:

- | | |
|-------------------------------------|--------------------------|
| Evidence of qualifications/training | <input type="checkbox"/> |
| References/witness statements | <input type="checkbox"/> |
| Curriculum Vitae | <input type="checkbox"/> |
| Fee / SoR membership number | <input type="checkbox"/> |