

Iowa Department of Public Health
Bureau of Radiological Health
Authorization Program

Re-Authorization Application

Facility Name			
Address			
City			
State & ZIP			

Telephone		FAX	
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Contact Person			
Telephone			
E-Mail			

Lead Interpreting Physician		Telephone #	
Hospital Administrator/CEO		Telephone #	

Has this facility been previously accredited?	YES	NO
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IF YES	MQSA ID No.		MQSA Expiration Date	
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WORKLOAD INFORMATION:	
Total Yearly Patient Volume:	
Number of Screening Examinations:	
Number of Diagnostic Examinations:	

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Iowa Department of Public Health

Facility Name			
Number of Units at Facility			
Any Mobile Units? (If Y, contact IDPH)	Y	N	

Make copies of this page for each additional mammography unit.

Mammography Unit Information

Unit Room Name or Number			
Manufacturer		Model	
Serial No.		Manufacture Date	

Type of Recording System (Check all that apply)	<input type="checkbox"/> Film-Screen	<input type="checkbox"/> Full Field Digital	<input type="checkbox"/> Computed Radiography
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If the above unit replaces an existing unit, please complete this section for the unit to be removed:

Manufacturer		Model	
Serial No.		Manufacture Date	
Date Removed from Service			

NOTE: ONLY NEEDED IF ADDING NEW UNITS AT REAUTHORIZATION TIME
Before a new (to your facility) unit may be used on humans, IDPH Authorization Program must receive and approve:

- **Radiation Shielding Plan**
- **New Mammography Facility Application**
- **Medical Physicist Mammography Survey and Mammography Equipment Evaluation** (*performed within 6 months prior to application*)

May submit all materials together, or each individually as acquired. Final approval will be granted when all items are received and reviewed.

SUBMIT 60 DAYS PRIOR TO FACILITY EXPIRATION:

- **Phantom Image taken within 1 week of submission**
- **Medical Physicist Survey**

FFDM and CR must submit Phantom images on HARD COPY

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Facility Name			
Number of Mammography Processors			<i>If multiple processors, printers, or review stations, make copies of this form for each.</i>
Number of Mammography Laser Printers			
Number of Mammography Review Workstations			

Processing and Review Information

(Fill out information applicable to your facility)

SCREEN-FILM			
Film Manufacturer		Film Type	
Processor Manufacturer		Model	
Date of Manufacture		Serial No.	
Developer Type			

FFDM or CR Hard Copy	Location/Room Name:		
Printer Manufacturer		Model	
Date of Manufacture		Serial No.	

FFDM or CR Soft Copy	Location/Room Name:		
Review Workstation Manufacturer		Model	
Date of Manufacture		Lt. Monitor Serial No.	Rt. Monitor Serial No.

COMPUTED RADIOGRAPHY (CR) READER			
Reader Manufacturer		Model	
Date of Manufacture		Serial No.	

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Facility Name

1. The information in this application and its attachments are truthful and accurate.
2. The radiation machine(s) is specifically designed for mammography.
3. The mammography unit(s) meets the equipment requirements described in FDA's Quality Mammography Standards (effective 4/28/99).
4. Iowa Department of Public Health will be notified in writing within 30 days of any changes to this application.
5. All personnel meet the applicable MQSA and State of Iowa requirements.
6. Lead Interpreting Radiologist has reviewed the procedure manuals and they are appropriate.

False statements and/or failure to report changes to this application may result in disciplinary actions against your facility's authorization status.

This must be signed by the lead interpreting physician or the administrator at your facility.

Signature
Lead Radiologist Administrator/CEO
(circle one)

Print Name

Date _____

NOTE: Your signature on this document assures that your facility will meet all provisions of the rules that relate to the mammography services provided.

Please submit the completed application and required materials to the address below. Please print or type all information except signatures.

For questions call (515) 281-0405

**Iowa Department of Public Health
Bureau of Radiological Health
Lucas State Office Building
321 E 12th Street
Des Moines, Iowa 50319**