TEXAS Health and Human Services
Texas Department of State Health Services

MAMMOGRAPHY CERTIFICATION APPLICATION

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
RADIATION SECTION - MAMMOGRAPHY BRANCH
Mail Code 1986
P.O. Box 149347
Austin, Texas 78714-9347
Phone #: (737) 218-7087
Fax #: (512) 203-3787
Email: MammographyBranch@dshs.texas.gov

AMENDMENTS

- **Retain a completed copy of the application for your records.**
- **Email us with any questions.**
- ***✸ See page 5 for further information.***

SECTION 1: FACILITY INFORMATION

1. TYPE OF ACTION: *(mark all that apply)*

❒ Business Name Change ✸ ❒ Assumed Name Change ✸
❒ Radiation Safety Officer (RSO) Change ✸ ❒ Lead Interpreting Physician (LIP) Change ✸
❒ Facility Contact Change
❒ Add Mammography Unit ❒ Add Digital Breast Tomosynthesis to existing unit
❒ Add Mobile Authorization ❒ Add Self-Referral Authorization
Address Change *(mark all that apply)*: ❒ Mailing ❒ Physical ❒ Billing

2. CERTIFICATION #: M_____

3. ACCREDITATION BODY: ☐ STX ☐ ACR

4. MQSA FACILITY IDENTIFICATION NUMBER: (6 digits) _____

5. LEGAL BUSINESS NAME *as filed with the Texas Secretary of State:*

_____

6. ASSUMED NAME (dba), if applicable.:

_____

7. PHYSCIAL USE LOCATION:

Phone #:_____ Facility Fax #: _____

Street Address: _____ City:_____

State: _____ Zip:_____ County*:* _____

8. BUSINESS MAILING ADDRESS:

Phone #:_____ Business Fax #: _____

Street Address: _____ City:_____

State: _____ Zip:_____ County*:* _____

9. BILLING MAILING ADDRESS: ❒ Same as business mailing address

Phone #:_____ Billing Fax #: _____

Street Address: _____ City:_____

State: _____ Zip:_____ County*:* _____

LEGAL NAME: _____ **M**_____

SECTION 2: FACILITY POLICIES & PROCEDURES:

Refer to 25 TAC §289.230 for specific details

SELF REFERRAL AUTHORIZATION:

Self-referral authorization must be obtained prior to providing self-referral mammography services.

Complete the section below and submit required documentation:

Number of views for a typical mammogram: _____

Type of views for a typical mammogram: _____

The age range of the population that will be examined: _____

The frequency of the exam: _____

Submit procedures for the following:

- Recommending a physician to patients who do not have physician.
- Notifying patients and private physicians of the mammography results within the required time frames.
- Description of the methods for educating patients in breast self-examination techniques and on the necessity for follow-up by a physician.
- Follow-up with patients and physicians of the mammography results for patient with positive findings and needing repeat exams.

MOBILE SERVICE AUTHORIZATION:

Approval must be obtained prior to providing mobile mammography services. Operating outside of Texas is not allowed with Texas Certification.

Complete and submit required documentation requested below:

List the street address where the mobile van and records will be maintained for inspection.

_____

Street City State Zip

SUBMIT THE FOLLOWING:

- A sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.
- A current copy of the facility's Operating and Safety Procedures regarding radiological practices for protection of patients, operators, employees, and the general public.

LEGAL NAME: _____ **M**_____

SECTION 3: FACILITY CONTACTS:

1. LEAD INTERPRETING PHYSICIAN (LIP):

Name: _____ Title: _____

Phone #: _____ Email address:_____

2. RADIATION SAFETY OFFICER (RSO)

Name: _____ Title: _____

Phone #: _____ Email address:_____

All correspondence will be sent to this email address. Ensure this email address is monitored.

3. FACILITY CONTACT:

Name: _____ Title: _____

Phone #: _____ Email address:_____

SECTION 4: MAMMOGRAPHY UNIT INFORMATION

Make copies of this page, if needed for additional units.

- Complete applicable sections and check all appropriate boxes.
- Include a copy of a current complete medical physicist's survey report for each mammography unit.
  - Medical physicist surveys for new facilities or new mammography units must be dated within 6 months of application.
  - Medical physicist surveys for renewals must be dated within 14 months of application.
  - If there are any failures and/or deficiencies on the report include copies of service/work invoices with the description of corrective actions.

MAMMOGRAPHY UNIT INFORMATION											
Location		Manufacturer	Model Name	Control Panel Serial #	Type of Imaging System				Additional Services	
Onsite	Mobile Van				DR	CRm	FFDM	DBT	Biopsy	NL
☐	☐				☐	☐	☐	☐	☐	☐
☐	☐				☐	☐	☐	☐	☐	☐
☐	☐				☐	☐	☐	☐	☐	☐

SECTION 5: REVIEW WORKSTATION INFORMATION: Adding Unit

You must verify the locations of the review workstations where the interpreting physicians interpret mammograms for your facility. List all review workstations where mammograms are interpreted, including private residences. If necessary, attach an additional page.

For each RWS, include a current copy of the new or annual RWS medical physicist survey report.

RWS Manufacturer	RWS Location		If you checked 'Different', provide facility name and address. *(Note: this includes private residences)*
	Same as DM unit	Different	
	☐	☐	
	☐	☐	
	☐	☐	

LEGAL NAME: _____ **M**_____

SECTION 6: SIGNATURES

This application is to be signed by the Authorized Representative of the Applicant, an individual with the capacity and authority to legally bind the Applicant.

Certification must be made by the person completing the application.

I certify that all information submitted with this application is true and correct to the best of my knowledge.

Typed or printed name _____ Title _____

Signature _____ Date _____

Certification must be made by the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.

I certify that all of the information provided herein is true, correct, and complete. I certify that the Applicant has read, understands, and will comply with applicable provisions of the Chapter 401 of the Texas Health and Safety Code, titled *Texas Radiation Control Act,* and with all applicable provisions or Title 25, Texas Administrative Code, Chapter 289, titled *Radiation Control.*

Typed or printed name _____ Title _____

Signature _____ Date _____

Certification must be made by the Lead Interpreting Physician.

I certify that I have read and understand Title 25, Texas Administrative Code, Section 289.230, titled *Certification of Mammography Systems and Mammography Machines Used for Interventional Breast Radiography.* I certify that I am qualified to serve, agree to serve, and will carry out those duties and responsibilities of the Lead Interpreting Physician of the Applicant, pursuant to 25 TAC §289.230.

Typed or printed name _____ Title _____

Signature _____ Date _____

Certification must be made by the Radiation Safety Officer.

I certify that I have read and understand and will comply with applicable provisions of the Chapter 401 of the Texas Health and Safety Code, titled Texas Radiation Control Act, and with all applicable provisions or Title 25, Texas Administrative Code, Section 289, titled Radiation Control. I certify that I am qualified to serve, agree to serve, and will carry out those duties and responsibilities of the Radiation Safety Officer of the Applicant, as set forth in the Radiation Control rules, 25 TAC §289.226.

Typed or printed name _____ Title _____

Signature _____ Date _____

Correspondence, including certificates, is sent by email only to the Radiation Safety Officer. Ensure that the email address provided is monitored.

Visit our website to download the appropriate documents listed below:

https://www.dshs.state.tx.us/radiation/mammography/certification.aspx

✸ **ADDITIONAL FORMS TO SUBMIT WITH APPLICATION:**

- RC 226-01 Business Information Form
- RC 42-R Radiation Safety Officer