



# UMP

## UPSTATE MEDICAL PHYSICS

Diagnostic Radiology, Medical Nuclear, Medical Health and Therapeutic Radiological Physics, PC.

Affiliated with Global Physics Solutions - a LANDAUER® company

Robert Pizzutiello, MS  
FACR • FAAPM • FACMP  
President

1290 Blossom Drive  
Victor, NY 14564

p • (585) 924-0350

f • (585) 924-5765

[www.upstatemp.com](http://www.upstatemp.com)

### Medical Physics Oversight Checklist New X-Ray Tube – Radiographic/Fluoroscopic Units

The following checklist has been created based on the NYSDOH Guide for Radiation Safety/QA Programs Appendix A. This checklist should be submitted by the supervisor of the Radiology Department for review by a New York State licensed Medical Physicist. Following installation of a new tube Medical Physics oversight **prior to first patient use** is to promote best patient care practices while maintaining a strong quality assurance program.

\_\_\_\_\_

Facility

\_\_\_\_\_

Unit/Room Identification

#### Step 1. Qualified Service Engineer

- New Tube Installed (Date: \_\_\_\_\_ )
- Post-Installation Service performed on unit which included the following evaluations:

*Check all that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> Half-Value Layer | <input type="checkbox"/> Exposure Reproducibility       |
| <input type="checkbox"/> kVp Accuracy     | <input type="checkbox"/> Collimation                    |
| <input type="checkbox"/> mAs Linearity    | <input type="checkbox"/> Typical/Maximum Exposure Rates |

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date of installation*

#### Step 2. Radiology Management - Prior to First Patient Use

- Sent this form to Upstate Medical Physics (Fax: 585-924-5765)
- Attached results of Service Engineer's report (*if available*)

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date form sent to UMP*

#### Step 3. Upstate Medical Physics, NYS Licensed Medical Physicist

- Reviewed supplied documents
- Returned signed form to client
- New Tube testing to take place within 30 days of new tube installation

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date of review*

*Upon return of this signed document to the facility, use of the equipment on patients can resume*