SWOG

DATE: _____

Return to: Roy H. Decker, M.D., Ph.D.
Yale University
Dept of Therapeutic Radiology
PO Box 208040
New Haven, CT 06520-8040
Phone: 203-727-2758
FAX: 203-785-6781

I. RADIATION THERAPY DEPARTMENT DATA:

_____ _____
Name of hospital, office or clinic — Street address

_____ _____
Therapeutic radiologist-in-charge — City, State and Zip

_____ _____
Member Institution for Affiliates **and indicate if** AFFILIATE or NCORP (**Please indicate one.**) — (Area code) Phone number

_____ _____
Name of Radiation Therapy Contact Person — Phone # for Contact person if different from above

_____ and E-mail _____
FAX NUMBER (to fax radiotherapy number approval letter)

II. CLINICAL PERSONNEL: Indicate whether full-time or part-time

A. Radiation Oncologists: Indicate how much time spent at member institution, AFFILIATE institution.

_____

_____

_____

B. Technologists: Indicate whether certified RTT

_____

_____

_____

C. Radiological Physicists and Dosimetrists:

_____

_____

_____

D. Other: (Including Data Managers & Nurse Oncologists)

_____

_____

_____

III. PATIENT CASELOAD:

A. Please give most recent annual statistics and indicate year from which these data are derived:

Year: _____

Total patients treated: _____
(give number)

IV. FACILITIES:

Total square footage _____

V. EQUIPMENT:

Please provide the following information for treatment machines, dosimetry computer, simulator, etc.

Type of Equipment	Manufacturer/Model	Year of Acquisition	Special Features (if any)

_____

_____

_____

_____

_____

VI. RADIATION PROTECTION:

1. Please name the designated Radiation Safety Officer for your department.

   _____

2. Name the individual who performs regular calibration of your therapeutic radiologic equipment and give the frequency of these services.

   _____