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RPAZ-LP-500

RADIATION PROTECTION AUTHORITY OF ZIMBABWE

RADIATION PROTECTION ACT [CHAPTER 15:15]

INSTRUCTIONS: (i) Provide ALL the requested information
(ii) Information in item numbers 2 to 4 should be provided for each equipment/facility. Use page duplicates
(iii) Tick appropriate box, and use separate sheet where necessary

NOTE: The Authority may require additional information to fully consider this application prior to issuing a license

APPLICATION FOR AUTHORISATION TO POSSESS AND USE RADIOTHERAPY SOURCE(S)

IV- I GENERAL INFORMATION

(a) Name of Applicant/Institution:

………………………………………………………………………………………………….

………………………………………………………………………………………………….

Address:……………………………………………………………………………….

………………………………………………………………………………………………….

Telephone No………………….FaxNo.…………………E-mail……………………..............

(b) Classification of the Applicant: Government ☐ Non – Government ☐

(c) Type of license Application: New ☐ Amendment ☐ renewal ☐

(d) Purpose of application: Construction ☐ use/operation ☐

(e) Name and Title of the head of Institution: ………………………………
……………………………………………………………………………….

(f) Person responsible for radiation safety:

Name:……..Title:……

Qualification:……Certification:……

Experience:……

(g) The Representative of the Legal Person

Name: …… Telephone Number: …….

Title: …… Fax Number: …….

E-mail address:…..……..……..……..……..……..……..……..……..……..……..……..

(h) Radiation qualified experts (e.g. Radiation Oncologist, Radiologist, medical physicists etc)

Name	Title	Qualification	Certification	Experience	Registration No.

(i) Proposed date of Commissioning of Facility (for new applications):

Name	Title	Qualification	Certification	Experience	Registration No.

External beam therapy...…….....……..

Brachytherapy……..

SOURCES AND EQUIPMENT

(a) For external beam therapy

Type of Unit: Accelerator □ Gamma □

Manufacturer's name.....

Address:.....
.....
.....

Model no. and name.....
.....

Country of Manufacture.....

Year of manufacture:.....

Type of gantry: Stationary □ Rotary □

Output Gy/min:.....

Describe the movement of the treatment table
.....
.....
.....

(i) For accelerator units:

Type of Radiation	Maximum Energy (kV)	Maximum current (mA)

(ii) For gamma units:

Supplier of Source and Address	
Radionuclide	
Model no. of source	
Initial activity of source	
Maximum design activity	

Total activity installed	
Type of source carrier/ shutter	

Please attach documentation with descriptions on the following features that will be available, including:-

(i) External beam therapy electrical indicators/ Interlock

(ii) External beam source head displays

(iii) Teletherapy control console displays

(iv) Teletherapy control console functions

(b) Brachytherapy

Devices:

PLEASE TICK WHERE APPROPRIATE

Manufacturer:	Model no	radionuclide	Type of loading: Manually M) Remote(R)	Dose Rate: High(H) Low(L)	Number of channels: (Remote)	Maximum activity
			M R	H L		
			M R	H L		
			M R	H L		
			M R	H L		

Sources:

Manufacturer:	**Model no:**	**Radionuclide**	**Physical type:** **Ribbon (R) Wire(W) Individual (I)**	**Physical dimensions and shape**	**Total activity(per cm for wires and ribbons)**	**Number of sources:(total activity for wire)**
			R W I			
			R W I			
			R W I			
			R W I			
			R W I			
			R W I			
			R W I			

Standards

Indicate to which IEC and ISO standards the equipment and sources used for medical exposure conform:

Equipment.....

Are prototype test certificates available: Yes □ No □; if yes attach copies

Sources.....

Are source certificates available: yes/no; if attach original copies

Services and maintenance

Identify who will be authorized to perform the service and maintenance of the equipment:

Name: .....Authorization reference no.....

Organization.....

Address: .....

Telephone Number.....

FACILITIES

Location of equipment/ Sources

Provide the details of the location of equipment / sources

	EXTERNAL BEAM THERAPY	BRACHYTHERAPY
Name of unit		
Building no.		
Room no.		
Place Land reg no./plot no.		
Location : town street ward		
District		

Region		

Layout of the installation

(a) Describe factors such as the layout of the facility and its safety systems including (i) building materials (ii) alarms (iii) shielding (iv) engineering controls

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(b) Safety assessments:

(i) Taking into account of shielding, provide calculation of maximum dose rates in all adjacent areas outside the installation:

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(ii) Provide estimates of the magnitude of the expected doses to persons during normal operations:

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(iii) Identify the probability and magnitude of potential exposures arising from accidents or incidents:

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(*Attach a layout drawing of the installation showing adjacent surroundings with controlled and supervised areas clearly identified)*

SECURITY AND SAFETY OF RADIATION SOURCES

Describe measures to be undertaken to ensure the security and safety of radiation sources during:

Use.....
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.....
Transport.....
.....
.....
Storage.....
.....
.....

Radioactive waste management:
How will the generated radioactive wastes be managed?

(a)Source(s) returned to the supplier: Yes ☐ No ☐ ;If yes attach a copy the agreement; if no

(b) how will it be managed in the country?

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.....

Emergency procedures:

Is an emergency plan available? Yes ☐ No ☐ ; If yes, attach the summary of the plan and related information e.g. organization, implementation etc.

Other radiation protection and safety requirements:

(i) Occupational and public exposures control: Describe your program for monitoring your work place (dose rate measurements, leak tests etc.) including any dose constraints to be applied,

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(ii) Medical exposures control: Describe your program for ensuring the radiation protection of patients and/or comforters during treatment with reference to the patient flow in your department (e.g. diagnosis, prescription, simulation, physical dosimetry and treatment planning, patient set up, records keeping, patient follow up etc.):

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(iii) Indicate other ancillary equipment/facilities available to suppor radiotherapy activities (e.g. CT scanner, simulator, Treatment planning system, MRI, Mammography unit, ultra sound, nuclear medicine etc):

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Declaration:

I,.....(*name)*certify that all the information given herein is true and correct to the best of my knowledge.

Signature :.....

Date:..... Official stamp:.....

For Official Use Only

(i) Date at which application form was received.....
(ii) Date at which the application was evaluated.....
(iii) Licence / Registration No.: .....
(iv) General remarks and/or comments: .....

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