PHYSICIST LETTER OF CERTIFICATION
FOR
DIAGNOSTIC RADIOGRAPHY, COMPUTED TOMOGRAPHY (CT) FACILITIES, INTERVENTIONAL IMAGING, RADIATION THERAPY FACILITIES, PROTON THERAPY, NUCLEAR MEDICINE AND/OR MAGNETIC IMAGING FACILITIES

Date:
CON Number:
Facility Name:
Facility ID Number:
Facility Address:

NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure, and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237
To The New York State Department of Health:

I hereby certify that for:

A. Diagnostic Radiography, Computed Tomography (CT) Facilities, Interventional Imaging and Radiation Therapy Facilities;

1. I have been retained by the aforementioned facility, to provide medical physicists services, in conjunction with the construction documents prepared by a NYS Licensed Architect/Engineer.

2. I have exercised due diligence and, to the best of my knowledge, information and belief, the radiation protection designed and specified for the above-referenced project is in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR 711.2 including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities and that the radiation exposure to the public and staff is designed to be as low as is reasonably achievable (ALARA), based on the work load provided to me by the facility for the proposed equipment and sound radiation protection principles.

3. Further, I agree to ensure that a current report detailing the extent of the radiation protection by the facility and the design of the protection systems will be made available to the Regional Office staff of the NYS Department of Health during the final inspection of the facility. I have informed the applicant that such report must be maintained on site as a permanent record.

B. Magnetic Resonance Imaging (MRI) Facilities, Interventional and Intraoperative MRI (I-MRI) Facilities;

1. I further certify that I have exercised due diligence and, to the best of my knowledge, information and belief the MRI magnetic shielding and radio frequency shielding as designed and specified are in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR

711.2, including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities.

2. I have reviewed the manufacturer's certifications accompanying all relevant equipment to ensure that such certifications satisfy all the requirements for patient, operator, and public safety.

3. I agree to submit an Architectural floor plan identifying the proposed MRI location, delineating all areas of the room and including the 5 Gauss line in three-dimensional planes, demonstrating that the electromagnetic and radio frequency environment is appropriate for the locations indicated are being submitted simultaneously with this Letter of Certification.

C. Description (Circle applicable facility type):

Diagnostic Radiography, Computed Tomography (CT) Facilities, Interventional Imaging, Radiation Therapy Facilities, Proton Therapy, Nuclear Medicine, Magnetic Resonance Imaging (MRI) Facilities

_____
Signature of Medical Physicist

_____
Name of Medical Physicist (Print)

_____
Business Address

_____
Business Telephone

The undersigned applicant understands and agrees that, notwithstanding this Medical Physicist certification the Department of Health shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Division to comply with the above- mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.

_____
Authorized Signature for Applicant

_____ _____ _____
Date Name (Print) Title

Notary signing required for the applicant

_____ . _____

STATE OF NEW YORK)
) SS:
County of _____)

On the ____ day of _____20__, before me personally appeared _____, to me known, who being by me duly sworn, did depose and say that he/she is the _____ of the _____ _____, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary) _____