Introductory Memorandum

TO: Medical Physicists

FROM: Brian Monzon, MBA, RT(R) (T), Manager
Radiation Oncology ACR M-P PEER™ Program

SUBJECT: Radiation Oncology ACR M-P PEER™ Program for Maintenance of Certification

The American College of Radiology is pleased to offer radiation oncology medical physicist(s) the opportunity to fulfill Part IV: Assessment of Performance in Practice for the Maintenance of Certification (MOC) program for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation (ROPA) Program. Similar to R-O PEER™, this Practice Quality Improvement (PQI) program will not require the submission of any additional cases; the PQI review will be conducted concurrently with the facility's ROPA on-site survey.

If there are two or fewer medical physicists at a practice, each participating medical physicist will need to make available, during the ROPA on-site survey, two cases that are documented and checked by that physicist. Pricing for the individual is included on the application.

Following the ROPA survey, a final ACR M-P PEER™ report will be issued to the participating medical physicist(s). If any recommended action measures are identified, the final report will request additional documentation that demonstrates that such measures have been appropriately addressed. Upon satisfactory completion, each medical physicist who participates in ACR M-P PEER™ will receive a certificate.

The application for ACR M-P PEER™ is attached. Those who would like to take advantage of this program should include this application and the appropriate fee along with the site's application for accreditation. ***All applicants participating in ACR M-P PEER™ must submit their application before their scheduled site survey.***

If you would like additional information, please contact the Radiation Oncology **ACR M-P PEER™** Program at 1-800-770-0145 x3711 or e-mail at rad-onc-accred@acr.org

Original or digital signatures are required on this form. Stamps are unacceptable.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, Virginia 20191-4397

ACR M-P PEER™ AGREEMENT (Individual Only)

The undersigned hereby requests a review of his/her patient cases and relevant clinical documentation including but not limited to patient treatment records (charts), simulation films, port films, DRRs, isodose plans and any other treatment planning or patient information necessary to complete case reviews. This review will be conducted concurrently with the facility's Radiation Oncology Practice Accreditation (ROPA) on-site survey.

The purpose of this request is to fulfill the Practice Quality Improvement (PQI) component of Maintenance of Certification (MOC) for the American Board of Radiology (ABR) through the ROPA Program. The cost of the review will be paid for by:

Name of Participating Medical Physicist: _____

Name and Address of Professional Corporation/Partnership: _____

_____

E-mail Address: _____

As a condition of receiving the requested review, I agree to:

1. Individual Medical Physicist at a practice during the ROPA Survey. Only individuals practicing at a facility with two or fewer Medical Physicists are eligible to apply as individuals. Each medical physicist must apply separately:

   ☐ Fee of $200.00 (ACR member)

   ☐ Fee of $ 300.00 (non-ACR member)

   The fee should be submitted to the ACR office with this signed agreement and the ACR M-P PEER™ application components. Fees are not refundable.

2. Provide any necessary additional information requested by the review team including an improvement plan in response to recommendations and appropriate follow-up data.

3. Receive the written final report and any peer review information.

The undersigned hereby releases and forever discharges the ACR, its directors, officers, members agents, volunteers, and employees from and against any and all claims, suits, damages, losses, expenses (including attorneys' fees) and liabilities by reason of, arising out of, or related to participation in the aforesaid review of the practice assessment of radiation oncology medical physics and the making of any report, statement, or recommendation, or failure to make a report, statement or recommendation, or the loss, damage or destruction of any image, record or other items received from the facility with respect to the aforesaid practice assessment of radiation oncology medical physics, including but not limited to any such claims or other matters based on alleged or actual negligence, antitrust, misconduct, defamation, personal injury or economic loss, catastrophic event (flood, fire, wind or another similar event), failure to receive a satisfactory report or any actions that may be taken by others as a result of this review, when such activities performed by or on behalf of ACR are done in good faith and without malice in connection with conducting this review.

The undersigned also agrees that the ACR is a health care entity as defined by the Health Care Quality Improvement Act of 1986 (HCQIA), and thus is afforded all the protections due to such entities under HCQIA, and all documentation collected as part of the review process be considered peer review, privileged and confidential communications.

The above obligations are agreed to and understood. These obligations will survive the grant or denial of a certificate of satisfactory completion of practice assessment by the American College of Radiology.

I certify that the information provided is true and correct.

Executed on _____ 20_____ _____
Date Signature Medical Physicist

_____
Printed Name Medical Physicist

The individual ACR M-P PEER™ report will be issued to the above-signed Medical Physicist.

☐Check enclosed, made payable to ACR ***OR***
☐Charge credit card

Please fill in all credit card information except the card number and CVV number. DO NOT fill in the card number or CVV number prior to faxing for security reasons. Please provide the contact person and telephone number at the bottom of this page so that an ACR representative can call them to obtain the credit card number.

Card No. ____XXXX-XXXX-XXXX-_____ **Exp. Date** _____ **CVV #**_____

☐ VISA ☐ MasterCard ☐ American Express

Name of Cardholder: _____

Billing Address: _____

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Mail your completed payment form to AMERICAN COLLEGE OF RADIOLOGY
ATTN: ACR M-P PEER™ Program
1891 PRESTON WHITE DRIVE
RESTON, VA 20191

OR you may **FAX** to **(703) 390-9836.**

DO NOT MAIL AND FAX THE SAME PAYMENT FORM!

Contact Person_____
Telephone Number_____ Fax Number_____
Email address _____
The ACR retains the right to issue a written report upon written request to any of the signatories of this agreement.