Ultrasound/Breast Ultrasound Equipment Annual Survey Summary

Facility Name:		
UAP/BUAP #:	Unit #:	Report Date:
Serial Number:		Survey Date:
System Manufacturer:		Model:
Medical Physicist or designee (Print name):		
Medical Physicist or designee (Signature):		

Equipment Evaluation Tests

Required	Pass/Fail *	Comments
1. Physical and Mechanical Inspection		
2. Image Uniformity and Artifact Survey		
3. System Sensitivity		
4. Scanner Electronic Image Display Performance		

Were all clinically used transducers tested? ☐ YES ☐ NO

Optional	Pass/Fail *	Comments
1. Primary Interpretation Display Performance		
2. Contrast Resolution		
3. Spatial Resolution		
4. Geometric Accuracy		

Overall comments:

*If any Fail result is indicated above, documentation of corrective action is required.

Revised 10/27/2020