

**HEALTHPLUS IMAGING MANAGEMENT PROGRAM  
IN-OFFICE ASSESSMENT FORM  
SUPPLEMENT**

**INFORMATION ON NON-ARRT PERSONNEL PERFORMING IMAGING TESTS**

Name \_\_\_\_\_

Physician Name(s) \_\_\_\_\_

Specialty \_\_\_\_\_

HPM Provider ID # \_\_\_\_\_

Office Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Formal education to perform radiology tests, including years of education, dates, place of education, degrees/certifications received, etc. Use additional sheets if necessary.

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Attach copies of certificates or other documentation of completion.

Years performing radiology tests, locations, etc.

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Types of tests performed

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Describe radiation safety training

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Additional information to support expertise in performing radiological exams.

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I hereby certify that the information provided above is true to the best of my knowledge.

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_