DXA Technologist Worksheet

Submit complete information for each interpreter at your facility. Use additional pages if necessary.

NOTE ALL PRIMARY TECHNOLOGISTS FOR APPLICATION.

Facility Name:

☐ **Primary DXA Technologist**

Name with credentials:
Mailing Address:
Mailing Address2:
Contact Phone number:
Contact Fax number:
Contact Email:

Please describe your DXA-related certifications:

☐ ISCD Bone Densitometry Technologist Certification (CDT/CBDT) Date Expired(mo.year):

☐ ARRT **Bone Densitometry Examination** (RT(BD)) Date Passed(mo.year):

Please describe your other DXA-related education and training:

☐ ISCD Bone Densitometry Technologist Course Mo/Year:
☐ ISCD Bone Densitometry Clinician Course Mo/Year:
☐ ISCD Vertebral Fracture Assessment Tech Course Mo/Year:
☐ ISCD Pediatric Bone Densitometry Course Mo/Year:
☐ ISCD Body Composition Course Mo/Year:
☐ Other(s) described below

Other Bone Densitometry Courses /Osteoporosis Training

Institution Name	Program or Divison (If applicable)	Year Completed	Length of Program

Continuing education (CE) activities related to bone densitometry or osteoporosis completed or attended within the past 3 years starting with most recent first: *The ISCD Facility Accreditation Committee feel it is important to remain up to date in Osteoporosis, Bone Density and Metabolic Bone Disease. Please list below.*

Program Title	Program Sponsor	CE/CEU's awarded	Year Completed	Location (City State) or web address

Please list your DXA scanning experience, most recent first:

Site / Location	**Year(s)**	**Approx Total Scans**

List *your* precision and LSC values *based on 95% confidence level (Mandatory, except where prohibited by law.)*

	Precision error as %CV	**Precision error as g/cm^2**	**LSC as %**	**LSC as g/cm^2**
Total Lumbar				
Total Hip				
Femoral Neck				

For each DXA technologist, please submit:

- Evidence of a self-performed *in-vivo* PRECISION ASSESSMENT for the values in the chart above. One option is to submit this in the form of ISCD Precision Calculator pages. Include information for Total Lumbar (Spine L1-4), Total Femur and Femoral Neck (use individual left OR right, not mean values).

Comments

DXA Scans Attestation and Cover Sheet for Technologists

Sign this cover sheet and attach scans.
One cover sheet per technologist.

For each DXA technologist, please submit:

- One baseline and one follow-up SPINE scan for the same patient performed by the same technologist*
- One baseline and one follow-up FEMUR scan for the same patient performed by the same technologist
- One FOREARM scan

Images must be clear. Please submit original printouts, NOT photocopies.
ISCD will not accept patient Protected Health Information (PHI). No patient identifiers should be seen on the scans. ISCD will immediately destroy all PHI material delaying your application.

Ensure that scans do contain:

- Patient birthdate (aged 89 or younger), height, weight, and gender
- Scan printouts displaying BMD, BMC, Area, Scan mode, Regions-of-interest including sub-regions
- Name of technologist who performed the scan and label each scan as either baseline or follow-up

Ensure that your DXA scan submissions demonstrate:

- Correct positioning, acquisition parameters, and analysis marker placement
- Consistent positioning and ROI placement between baseline and follow-up scans

Accreditation assessors need to know that you recognize a good positioning, analysis, and reproducibility

**If technologist is new and has not yet performed baseline and follow-up scans for the same patient, serial scans from that technologist's precision assessment may be submitted as a substitute. Serial scan submissions are required to demonstrate technologist reproducibility.*

Technologist Attestation:

The DXA Technologist signing below attests that scans submitted for ISCD Facility Accreditation are original work done by said technologist. The technologist also takes full responsibility for de-identifying scans submitted to ISCD so as not to contain any Protected Health Information.

Signature: _____

Name: _____

Title: _____

Date: _____