FAP 1160

DXA Interpreter Worksheet

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

NOTE ALL PRIMARY INTERPETERS FOR APPLICATION.

Facility Name:	

☐ **Primary Interpreter**

Interpreter Name with credentials:	
Mailing Address:	
City, State, Zip:	
Phone Number:	**Fax Number:**
Email:	**Website:**

Please describe your DXA-related certifications:

☐ ISCD CCD Certification Year Passed: Exp:
(*fill out CE activity section if not currentlyISCD certified)*

Please describe your other DXA-related education and training:

☐ ISCD Bone Densitometry Clinician Course Year:
☐ ISCD Vertebral Fracture Assessment Course Year:
☐ ISCD Pediatric Bone Densitometry Course Year:
☐ ISCD Body Composition Course Year:

Other Bone Densitometry/Osteoporosis Training, Fellowships, Clinical Rotations etc.

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 5 years starting with most recent first: *The ISCD Facility Accreditation Committee feels 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 interpretation experience, most recent first:

	Facility Name, Location	Years, dates of experience
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9		
10.		

DXA Reports Attestation and Cover Sheet for Interpreters

Sign this cover sheet and attach reports with scans.
One Cover sheet per Interpreter.

DXA Interpreters must submit one baseline and one follow-up DXA report from the same patient. The scans from each baseline report and follow-up interpretive report must also be included with this cover.

ALL IMAGES SUBMITTED MUST BE CLEAR. Please submit original printouts as opposed to copies of originals.

BMD, BMC, AREA, SCAN MODE, AND ALL REGIONS OF INTEREST (INCLUDING SUB-REGIONS) MUST BE VISIBLE.
TECHNOLOGIST, **INTERPRETER**, **DATE OF SCAN**, **PATIENT AGE*** AND **GENDER** MUST BE IDENTIFIED ON EACH SCAN AND INTERPRETIVE REPORT.

*if Patient age is over 89, you must use category “90+” for age. Do not disclose exact age over 89.

ISCD will not collect or maintain PHI material. In the event material is sent in error, ISCD shall protect the material from inappropriate disclosure/release by immediately destroying the PHI information and sending a notice to sender stating such. **This will seriously delay your application. Please de-identify all your material, scans and reports included.**

Interpreter Attestation:

The DXA Interpreter signing below attests that reports submitted for ISCD Facility Accreditation are original work done by said interpreter. The interpreter also takes full responsibility for de-identifying the scans and reports submitted to ISCD so as not to contain any Protected Health Information (PHI).

Signature: _____

Name: _____

Title: _____

Date: _____