The College of Radiographers will use the register details supplied by you for purposes associated with education such as the administration of events, research, promotion and fundraising, processing award applications and maintaining education records. Our lawful basis for processing your information is to manage your registration and fulfil our legitimate interest as a professional body. We will share some of your information with the Society of Radiographers and education centres requiring your services. We will retain all information you submit for the duration of your tenure as an assessor and thereafter as verification of your participation. For detailed information about how we use your information please see <http://www.sor.org/privacy-statement>

**Please word process this form**

## **Contact and employment details**

|  |  |
| --- | --- |
| Title |  |
| First Name |  |
| Last name |  |

**Correspondence address** (to be used when nominating assessors)

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Daytime telephone |  |
| Mobile no. |  |
| **Email address** |  |

|  |  |
| --- | --- |
| **Job title** (including grade |  |
| **Organisation**(Include department if applicable) |  |

## **Application details**

|  |  |
| --- | --- |
| SoR membership number: |  |
| HCPC Registration Number: |  |
| Other professional body membership number: |  |
| Advance HE Level of Fellowship (AFHEA, FHEA, SFHEA, PFHEA) if applicable: |  |

**Qualifications (including dates)**

|  |
| --- |
|  |

**Professional experience (including dates)**

|  |
| --- |
|  |

**Please indicate below which areas are you experienced and qualified to assess. (Please indicate the number of years’ experience in all boxes that apply):**

## **Discipline**

|  |  |
| --- | --- |
| **Discipline** | **Number of years’ experience** |
| Diagnostic Radiography |  |
| Therapeutic Radiography |  |

## **Approval of programmes**

|  |  |
| --- | --- |
| Assistant Practitioner |[ ]  Short Courses |[ ]
| Practice Educators |[ ]  Undergraduate (pre-registration) |[ ]
| Postgraduate (pre-registration) |[ ]  Degree Apprenticeship (pre-registration) |[ ]
| Postgraduate (post-registration) |[ ]  Degree Apprenticeship (post-registration) |[ ]

## **Accreditation of individuals**

|  |  |  |
| --- | --- | --- |
| Advanced Practitioner |[ ]  Assistant Practitioner (all assessors) | **🗸** |
| Consultant Practitioner |[ ]  Practice Educator |[ ]

## **Scope of practice**

|  |  |
| --- | --- |
| Brachytherapy |[ ]  PET CT / SPECT CT |[ ]
| Breast imaging screening |[ ]  Radiation protection |[ ]
| Breast imaging symptomatic  |[ ]  Radiotherapy imaging |[ ]
| Breast ultrasound |[ ]  Radiotherapy planning/dosimetry |[ ]
| CT |[ ]  Radiotherapy pre-treatment |[ ]
| CT Colonography |[ ]  Reporting - Abdomen |[ ]
| Dental radiography |[ ]  Reporting - Appendicular skeleton |[ ]
| DEXA/Osteoporosis |[ ]  Reporting - Axial skeleton |[ ]
| Forensic radiography |[ ]  Reporting - Chest |[ ]
| GI studies |[ ]  Reporting - CT |[ ]
| Gynaecology |[ ]  Reporting - DEXA |[ ]
| Interventional radiography/imaging - vascular |[ ]  Reporting - MRI |[ ]
| Interventional radiography/imaging - non-vascular |[ ]  Reporting - Musculoskeletal |[ ]
| IV administration |[ ]  Reporting - Paediatrics |[ ]
| Mammography |[ ]  Reporting - Trauma |[ ]
| Medical Physics |[ ]  Research |[ ]
| MRI |[ ]  Trauma imaging |[ ]
| Nuclear medicine |[ ]  Treatment prescribing/review |[ ]
| Paediatrics |[ ]  Ultrasound |[ ]

## **Others**

|  |  |
| --- | --- |
|  |[ ]   |[ ]
|  |[ ]   |[ ]
|  |[ ]   |[ ]

**Please state any additional areas of interest**

|  |
| --- |
|  |

**Please provide details of experience to support each of the activities ticked above**

|  |
| --- |
|  |

**If you wish to be involved in programme/course approval, please provide details of current involvement in education programmes and curriculum development.**

|  |
| --- |
|  |

**In the role of the assessor, it may be important to have a UK wide perspective. Please outline how your knowledge and experience enables you to apply such a perspective in the area in which you wish to assess.**

|  |
| --- |
|  |

**It is important to keep abreast of the policies and procedures. Please indicate how your professional experience enables you to demonstrate knowledge and understanding of professional body policies relative to radiography practice.**

|  |
| --- |
|  |

**Please indicate any other information relevant to this application**

|  |
| --- |
|  |

## **References**

Please provide details of two referees who can be approached to support your application.

**Referee 1**

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Address |  |
| Daytime telephone no. |  |
| Mobile telephone no. |  |
| Email address |  |

**Referee 2**

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Address |  |
| Daytime telephone no. |  |
| Mobile telephone no. |  |
| Email address |  |

**I agree to accept and work within the guidelines established by the Society and College of Radiographers**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

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Please return your completed application to: approval@sor.org