CT Imaging Certificate Program

SUMMARY OF CLINICAL COMPETENCE

for the
RADIOLOGICAL and/or NUCLEAR MEDICINE TECHNOLOGIST
2026

Candidate: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Phone: 613 234-0012 or 1 800 463-9729 (toll free in Canada)

specialtycertificates@camrt.ca or cpd@camrt.ca

EMAIL IS THE PREFERRED MODE OF CONTACT & ONLY EMAILED DOCUMENTS WILL BE ACCEPTED

Introduction & Outline of Responsibilities

The purpose of a Summary of Clinical Competence (SCC) is to allow **the technologist to record procedures performed under the supervision of a clinical advisor that attests to the technologist's competence** in the performance of imaging and associated procedures.

The Clinical advisor (CA) or Delegated Assessor (DA) attests to the consistent competent performance by the technologist for each procedure/competency. Each procedure/competency must be signed by the clinical advisor or delegated assessor on the date competency has been verified and confirmed. The CA/DA must witness competent practice for each procedure/competency multiple times prior to the date of the final assessment. Contact information regarding the candidate, CA and DA must be provided in the areas indicated. To assist the technologist and the CA, guidelines for assessment of the various competencies are provided in this document.

Competence is sometimes difficult to describe. For the purpose of this program, it is defined as the following:

- When presented with situations, **the technologist performs relevant competencies in a manner consistent with generally accepted standards and practices in the profession, independently and within a reasonable timeframe.** The technologist anticipates what outcomes to expect in a given situation, and responds appropriately, selecting and performing competencies in an informed manner. The technologist demonstrates transferrable skills between competencies.

- **The technologist recognizes unusual, difficult to resolve and complex situations which may be beyond their capacity. The technologist takes appropriate and ethical steps to address these situations**, which may include consulting with others, seeking supervision or mentorship, reviewing literature or documentation, or referring the situation to the appropriate healthcare professional.

- **Guidelines for observation** - Where a candidate is explicitly permitted to observe a competency in the SCC, the following guidelines for observation should be followed to demonstrate understanding of the competency's purpose, process and outcomes:
    - Introduce yourself appropriately to the patient (NOD)
    - Review the patient history and participate in the evaluation of any relevant requisition
    - Review procedure setup
    - Review procedure protocol
    - Observe procedure
    - Participate in the review and evaluation of any relevant images/results
    - Demonstrate professionalism in the workplace
    - Ensure all professionals signing off on observations are identified in the SCC on the Delegated Assessors' form.

There are **eight modules** to complete in this Summary of Clinical Competence.

Fully familiarize yourself with the program handbook before beginning your SCC.

Candidate Check List

It is important to note that program documents are updated annually and may differ from previous versions. It is the responsibility of the candidate to be aware and accountable of all aspects of these documents. All information in this SCC is mandatory and a blank piece of information may result in the need for a paid resubmission of the SCC.

<table>
<tr><th colspan="2">CTIC Program Overview</th></tr>
<tr><td rowspan="2">Certificate Components</td><td>Didactic (coursework) Requirement*
CT Imaging 1 (prerequisite)
CT Imaging 2
CT Imaging 3
CT Sectional Anatomy Exam
Quick Self Study (1 of 3 options)
*75%+ on each final exam/quiz is required.</td></tr>
<tr><td>Clinical (competencies) Requirement
Verification of Experience
A Summary of Clinical Competence (SCC)</td></tr>
<tr><td rowspan="4">Timelines</td><td>Candidates have 5 years from the date of completion of their first eligible pre-requisite course to complete all remaining requirements of this certificate program.</td></tr>
<tr><td>The Verification of Experience form is part of the SCC, and it is signed by your supervisor/manager before or during the completion of your clinical competencies. This is not a prior experience pre-requisite form. The candidate must practice in CT for at least 10 weeks (and no fewer than 350 hours) before submitting the SCC. This must take place after registration into the certificate program. This clinical experience may only be acquired as a certified medical radiation technologist practicing in CT with access to their experienced CA or DA.</td></tr>
<tr><td>Once registered in the certificate program, the candidate may begin working on their SCC and complete the competencies under supervision. Ensure you have your CA/DA pages signed at the time that they begin observing exams!</td></tr>
<tr><td>(1) Required Quick Self Study must be completed before or during the CTIC program, but must be no more than 5 years old at the time of the Summary of Clinical Competence (SCC) submission.</td></tr>
<tr><td colspan="2">SCC SUBMISSION IS THE FINAL STEP OF YOUR PROGRAM. Submit the final SCC via email in one document – including a checklist for each CA and yourself – for review to specialtycertificates@camrt.ca</td></tr>
</table>

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

CANDIDATE CONTACT INFORMATION

Candidate Name: FULL LEGAL NAME

Designation: SPECIALTY , i.e. RTR

Credential: ADD ANY CREDENTIAL HERE THAT YOU HOLD
(i.e. John Doe, RTR, CIR)

CAMRT ID: _____

Email: _____

Telephone Number: _____

How many years have you practiced CT? (at the time of beginning your SCC): _____

Year of Entry-to-practice Certification (CAMRT exam): THE YEAR YOU PASSED THE CAMRT EXAM TO BEGIN TO PRACTICE IN CANADA

Candidate's Employment Facility

Name & Mailing Address: INCLUDE FULL ADDRESS HERE (INCL POSTAL CODE)

_____

_____

Other Clinical Facility
(*if different from above*)

Name & Mailing Address: _____

_____

_____

Candidate's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date: COMPLETE THIS FORM AS YOU BEGIN THE SCC

The Role of a Clinical Advisor (CA)

To be read, understood and signed by <u>each individual acting as a Clinical Advisor at the beginning of their participation.</u>

To maintain the integrity of CAMRT Certificate programs, it is essential that all parties involved in the training and evaluation of certificate program candidates follow the procedures set out in the Program Handbook and Summary of Clinical Competence (SCC). A CAMRT Certificate indicates a level of competence above entry-to-practice that has been verified through the requirements of the program.

Clinical Advisor, please initial your acknowledgement below.

CA Responsibilities	
	Review Program Handbook and SCC with the candidate, including detailed guidelines for assessment of competency in each module
	Mentor and support candidates in their skill development and transferrable skill development
	Ensure all competencies are performed independently by the candidate (observations and simulations only allowed if explicitly stated in SCC; see guidelines in the SCC for more information) and contact the CAMRT if the candidate is unable cannot access a procedure or cannot consistently show independent skill and competence
	Sign (no initials, please) and date each competency/procedure in SCC at the time competence is established (individual repeatedly shows knowledge, skill, and judgement) following program registration
	Optional: Delegate assessment duties to Delegated Assessors (DA) who have the expertise and qualifications outlined in the Program Handbook and the guidelines for assessing competency in each module of this SCC, and are familiar with both documents
	Verify and declare candidate's overall competence by signing and dating the Declaration of Completion at end of clinical placement
CA Eligibility	
	I am a medical radiation technologist* with a CAMRT CTIC credential **OR**** I am a medical radiation technologist having a minimum of five years' experience in the practice of CT Imaging. **Other: _____
	I am **currently practicing** in CT
	I am **not** currently registered in any of the CAMRT CT Certificate programs
	I have no conflicts of interest with the CTIC candidate • Conflicts of interest may include close personal relationships that could threaten independence or objectivity during assessments, or a direct report (i.e. the assessor reports to the candidate). Please reach out with any questions to CAMRT.

I understand that any false or misleading statement, omission or misrepresentation may result in the candidate's automatic withdrawal from the program and/or revocation of the CTIC designation.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Clinical Advisor Signature **Date DD MM YYYY**

All entries must include the full date of the completed competency and the Clinical Advisor's/Delegated Assessor's signature (*not* initials). This page may be duplicated, if needed.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

CLINICAL ADVISOR(CA) CONTACT INFORMATION

CA Name: _____

Designation: JOB TITLE

Credential: INCLUDE SPECIALTY, i.e. RTR
(i.e. John Doe, RTR, CIR)

CA's Employment Site(s): _____

_____

Email: _____

Telephone Number: _____

How many years have you practiced CT? (at the time of signing this form)? ENSURE CA MEETS MIN REQUIREMENTS

It is understood that by signing off on the SCC competency lines as well as the overall modules in the SCC that the clinical advisor has witnessed competent practice for the procedure / competency consistently prior to the date of final assessment as outlined in the program Handbook and Assessment Guidelines. A signature verifies that the technologist has consistently shown they have the knowledge, skill, and judgement to be declared competent in this aspect of practice at a level that is significantly above an entry-to-practice level of skill. I understand the above and agree to support the candidate through this program:

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED _____ SIGN AT BEGINNING OF SCC _____

Clinical Advisor Signature **Date (full date, please DD MM YYYY)**

This page should be signed at the time (or before) beginning the SCC.

This signature must match the signatures on the rest of the SCC.

This page may be duplicated, if needed.

The CAMRT deeply appreciates your professionalism and commitment to helping the candidate continue their education in an ever-changing healthcare environment.

Please see the multiple contact signature page if you are using multiple assessors/sites.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

DELEGATED ASSESSOR (DA) CONTACT INFORMATION

Each CA is responsible for assigning their own delegated assessors and ensuring they have signed all forms and pages where these signatures appear.

DA Name: ALL NON-CA SIGNING AUTHORITIES IN THE SCC MUST BE LISTED AS DAs

Designation: _____

Credential: _____
(i.e. John Doe, RTR, CIR)

DA Site(s) of Employment: _____

Email: _____

Telephone Number: _____

How many years have you practiced CT? (at the time of signing this form)? ENSURE DA MEETS MIN REQUIREMENTS

It is understood that by dating and signing the indicated columns in the SCC the delegated assessor has witnessed competent practice for this procedure/competency several times prior to the date of the final assessment as outlined in the program Handbook and Assessment Guidelines. A signature verifies that the technologist has consistently shown they have the knowledge, skill, and judgement to be declared competent in this aspect of practice at a level that is significantly above an entry-to-practice level of skill. I understand the above and agree to support the candidate through this program:

_____ _____

Signature of Delegated Assessor **Date DD MM YYYY**

I verify that the above delegated assessors are credentialed and competent in their practice and approve their participation in completing this SCC.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

_____ _____

Clinical Advisor Signature **Date DD MM YYYY**

This page may be duplicated, if needed. Note that use of DAs should be kept to a reasonable level, to ensure that reviewers can track your SCC's completion. Contact pages should be completed at the time of beginning work as DA.

Please see the multiple contact signature page if you are using multiple assessors/sites.

MULTIPLE CONTACT SIGNATURE PAGE

If you are using multiple CAs, DAs or multiple sites to complete this SCC, please provide this signature page to assist our reviewers while they are assessing your SCC. Please consider limiting your assessors to ensure that you are being consistently observed. You can duplicate this as required. This is optional if you are using 2 or fewer CAs/DAs.

CA/DA Last Name: _____

Site: _____

Signature: _____
(must match SCC exam lines)

CA/DA Last Name: _____

Site: _____

Signature: _____
(must match SCC exam lines)

CA/DA Last Name: _____

Site: _____

Signature: _____
(must match SCC exam lines)

CA/DA Last Name: _____

Site: _____

Signature: _____
(must match SCC exam lines)

The Summary of Clinical Competence

Mandatory Competencies

Candidates must demonstrate competence in **all** mandatory competencies. All competencies must be performed on patients.

If there are procedures in the SCC that are not performed at your clinical site, it is the responsibility of the candidate to contact CAMRT to determine an alternate option (if any). You must retain or have access to a record of completed mandatory competencies in case of audit (i.e. PACS access).

Elective Competencies

Candidates must complete **a minimum of 10 elective** competencies. All electives must be performed clinically unless the SCC procedure indicates otherwise.

Competencies performed before program registration will not be considered for this program.

Notes:

- Do not include any patient or exam identifiers in the Summary of Clinical Competence
- A procedure on one patient may contribute to more than one competency in patient care and contrast media modules; however, it can only be used as one competency in Modules 3-8
- Clinical Advisor/Delegated Assessor signatures in the indicated columns in the SCC indicate that a CA or DA has witnessed competent practice for the procedure multiple times prior to the date of final assessment. A signature verifies that the technologist has consistently shown they have the knowledge, skill, and judgement to be declared competent in this aspect of practice.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 1: PATIENT CARE **Candidate Name: _____**			***Signature of Clinical Advisor/Delegated Assessor (full signature, not initials)***
Competency	***Status***	***Short description of competency***	*Note: Patient Care (DA may be a registered nurse/physician)*
CPR	Mandatory	Attach a current copy of healthcare provider CPR (Basic Life Support level or higher). CPR should be valid throughout the completion of the SCC competencies and **must** be valid at the time of SCC submission.	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Monitor Patient Vital Signs	Mandatory	Monitor patient's hemodynamic status, respiration, pulse oximetry and temperature	
Perform Patient Assessment	Mandatory	Monitor patient's conscious levels; assess patient's clinical history	
Follow Universal/Standard Precautions	Mandatory	Follow universal/standard precautions when handling a patient	
Review Exam Indications	Mandatory	Assess and verify clinical indications and contraindications for each procedure	
Perform Patient Transfer	Mandatory	Apply appropriate equipment, body mechanics and technique in patient transfers	
Monitor O_2 Administration	Mandatory	Monitor O_2 and IV administration to ensure patient safety	
Verify Informed Consent	Mandatory	Apply guidelines as per institution	
Provide Patient Education	Mandatory	Relay pre-& post procedure instructions to the patient and answer patient questions	

Module 1:
I attest that the candidate has <u>continually</u> demonstrated competence in "Patient Care":

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, or indicate DD MM YYYY): DATE MUST FOLLOW ALL COMPETENCIES BEING MET

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY THE DATE YOU REGISTER FOR THE CTIC PROGRAM

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 2: CONTRAST MEDIA ADMINISTRATION **Candidate Name: _____**			***Signature of Clinical Advisor/Delegated Assessor (full signature, not initials)***
Competency	***Status***	***Short description of competency***	*Note: Patient Care (DA may be a registered nurse/physician)*
Evaluate Lab Values	Mandatory	Assess BUN/creatinine/GFR prior to procedure	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Select Contrast Media	Mandatory	Assess patient history for possible contraindications and select appropriate contrast medium	
Prepare Contrast Media	Mandatory	Prepare contrast medium for administration	
Select Injection Site	Mandatory	Select appropriate anatomical site for venipuncture	
Perform Venipuncture	Mandatory	May be demonstrated by performing all steps excluding actual skin puncture in areas where venipuncture by the technologist is not authorized	
Operate Power Injector	Mandatory	Load injector, select protocol and inject contrast media	
Monitor Patient	Mandatory	Assess for adverse reactions	

Module 2:

I attest that the candidate has <u>continually</u> demonstrated competence in "Contrast Media Administration".

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

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MODULE 3: IMAGE MANIPULATION & QUALITY ASSURANCE **Candidate Name: _____**			***Signature of Clinical Advisor/Delegated Assessor*** ***(full signature, not initials)***
Competency	***Status***	***Short description of competency***	*Note: Delegated assessor may be a biomedical technologist/technician or physicist for the calibration competency.*
Perform Measurement	Mandatory	Perform measurements such as distance	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Perform ROI	Mandatory	Perform a region of interest measurement	
Perform Calibration	Mandatory	Perform air or water calibrations	
Apply Dose Reduction Strategy	Mandatory	Apply knowledge of dose modulation functions to minimize dose; reflect on dose reports; use Bismuth shield.	
Create MPR	Mandatory	Create a multi-planar reconstruction	
Create MIP	Elective	Create a maximum intensity projection	
Create 3D Reconstruction	Elective	Create a 3D reconstruction	

Module 3:

I attest that the candidate has <u>continually</u> demonstrated competence in the "Image Manipulation and Quality Assurance" module.

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

Assessment of Performance of Clinical Procedures

The following key areas are examples of best practice competence. Your signature at the bottom of each clinical module indicates that the candidate has met your expectations and has shown robust competence. The failure of the candidate in any of these key areas means that the competency should *not be signed* and retraining is required before completion of the SCC line. Please take the time you need to feel confident in signing off on these modules – the process of attaining competency can be iterative.

Please ensure that all of the following assessment criteria are observed:

- ☐ Evaluate the requisition form for the appropriateness of the requested study
- ☐ Preparation of examination room (including any required sterile techniques or other site protocols)
- ☐ Apply universal/standard precautions
- ☐ Verify patient identification (using two independent identifiers)
- ☐ Assess the patient for contraindications to, and consent to the procedure
- ☐ Provide education about the procedure
- ☐ Document appropriate patient history and allergies
- ☐ Position patient appropriately for scan, adjusting for patient needs
- ☐ Apply radiation protection, as required
- ☐ Select correct protocol and parameters
- ☐ Modify protocols and parameters, as required
- ☐ Select appropriate scan limits
- ☐ Confidently and correctly scan the patient
- ☐ Obtain, format and archive images
- ☐ Document procedure and appropriate patient data
- ☐ Evaluate scanned images for optimal image quality
- ☐ Evaluate scanned images for optimal demonstration of anatomy
- ☐ Evaluate scanned images for exam completeness
- ☐ Discharge patient with post-procedure instruction, if applicable

I verify that the candidate has consistently demonstrated the best practices listed above, as observed by myself or delegated assessors while completing clinical competencies in this SCC.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Clinical Advisor Signature **Date DD MM YYYY**

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 4: HEAD **Candidate Name: _____**		***Signature of Clinical Advisor/Delegated Assessor*** ***(full signature, not initials)***
Body part / Procedure	***Status***	***See Assessment of Performance of Clinical Procedure Guidelines on page 14 for full assessment criteria***
Enhanced Head	Mandatory	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Unenhanced Head	Mandatory	
Trauma	Mandatory	
Orbits/Facial Bones	Mandatory	
Sinuses	Mandatory	
Temporal Bones	Mandatory	
CTA Head	Mandatory	
TM Joints/IACs	Elective	
3D Bone Reconstruction	Elective	
Pituitary Gland	Elective	

Module 4:

I attest that the candidate has <u>continually</u> demonstrated competence in the "Head" module and met the assessment criteria guidelines above.

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 5: NECK & CHEST **Candidate Name: _____**		***Signature of Clinical Advisor/Delegated Assessor*** ***(full signature, not initials)***
Body part / Procedure	***Status***	***See Assessment of Performance of Clinical Procedure Guidelines on page 14 for full assessment criteria***
Enhanced Neck	Mandatory	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Enhanced Chest	Mandatory	
Unenhanced Chest	Mandatory	
Pulmonary Embolism	Mandatory	
Carotids	Mandatory	
Thoracic Aorta	Elective	
High Resolution Chest	Elective	
Cardiac	Elective	

Module 5:

I attest that the candidate has <u>continually</u> demonstrated competence in the "Neck & Chest" module and met the assessment criteria guidelines above.

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 6: ABDOMEN & PELVIS **Candidate Name: _____**		***Signature of Clinical Advisor/Delegated Assessor (full signature, not initials)***
Body part / Procedure	***Status***	***See Assessment of Performance of Clinical Procedure Guidelines on page 14 for full assessment criteria***
Enhanced Abdomen/ Pelvis	Mandatory	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Unenhanced Abdomen/ Pelvis	Mandatory	
Abdominal Aorta	Mandatory	
Liver	Mandatory	
Kidneys	Mandatory	
Pancreas	Mandatory	
Trauma Abdomen/ Pelvis	Elective	
Colonography	Elective	
Adrenals	Elective	
3D Vascular Reconstruction	Elective	

Module 6:

I attest that the candidate has <u>continually</u> demonstrated competence in the "Abdomen & Pelvis" module and met the assessment criteria guidelines above.

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 7: SPINE & EXTREMITIES **Candidate Name: _____**		***Signature of Clinical Advisor/Delegated Assessor (full signature, not initials)***
Body part / Procedure	***Status***	***See Assessment of Performance of Clinical Procedure Guidelines on page 14 for full assessment criteria***
Cervical Spine	Mandatory	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
Lumbar Spine	Mandatory	
Post-Processing/ **Retrospective (Spine/Extremity)**	Mandatory	
Lower Extremity	Mandatory	
Upper Extremity	Mandatory	
Bony Pelvic Structure	Mandatory	
Thoracic Spine	Elective	

Module 7:

I attest that the candidate has <u>continually</u> demonstrated competence in Spine & Extremities and met the assessment criteria guidelines above.

Clinical Advisor's Signature: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

MODULE 8: OTHER MODALITIES / MISCELLANEOUS **Candidate Name: _____**		***Signature of Clinical Advisor/Delegated Assessor (full signature, not initials)***
Body Part / Procedure	***Status***	See Assessment of Performance of Clinical Procedure Guidelines on page 14 for full clinical criteria. Where you are explicitly permitted to **observe** in the SCC, the following guidelines for observation must be followed: ➢ Introduce yourself appropriately to the patient ➢ Review the patient history and participate in the evaluation of any relevant requisition ➢ Review procedure setup ➢ Review procedure protocol ➢ Observe procedure ➢ Participate in the review and evaluation of any relevant images/results ➢ Demonstrate professionalism in the workplace ➢ **Indicate on this page if not completed your home site.**
CT-Guided Intervention **Observation** **or participation**	Elective – Please indicate which (i.e. biopsy, drainage, ablation...) and if you observed or participated	SIGN HERE WHEN THE COMPETENCY HAS BEEN CONSISTENTLY MET
SPECT CT ***Observation or participation** **Observation** **or participation**	Elective – Please indicate if you observed or participated	
PET CT **Observation** **or participation**	Elective – Please indicate if you observed or participated	
CT Simulation **(Rad Therapy)** **Observation** **or participation**	Elective – Please indicate if you observed or participated	

CT Pediatrics **Observation** **or participation**	Elective – Please indicate if you observed or participated. For the purpose of the CTIC, a pediatric exam **must include the use of adapted scan parameters** that are specific to an infant, child or adolescent.	
CT Perfusion **Observation** **or participation**	Elective	

Module 8:

I attest that the candidate has <u>continually</u> demonstrated competence in Other Modalities / Miscellaneous competencies and met the assessment criteria guidelines above.

Clinical Advisor's Signature:

Date Competence Assured (full date, please indicate DD MM YYYY): _____

Exam competence must be assured after registration into the certificate program. I attest that the candidate has completed these exams after their registration date.

PROGRAM REGISTRATION DATE (date registered into CTIC): DD MM YYYY _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

DEDICATED CT EXPERIENCE VERIFICATION

To be completed by the candidate's supervisor/manager.

I verify that _____ [candidate name] has practiced **full-time in dedicated CT no fewer than 10 weeks under supervision** (or the equivalent in working days of full shifts, equaling no fewer than 350 hours) as a certified medical radiation technologist while completing their SCC*.

Registration date into CTIC (DD/MM/YYYY): _____

Date CT experience requirement met (no less than 10 weeks after registration): MINIMUM REQUIREMENT

Estimated 24-hour department workload (number of CT-cases): MANDATORY

Please Print:

Supervisor/Manager Name: _____

Position: _____

Title/Credential: _____

Name of Facility: _____

Email: _____

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED _____ MUST FOLLOW DATE ABOVE _____

Signature of Supervisor/Manager | *Date DD MM YYYY (no earlier than the experience end date)*

CAMRT reserves the right to request a breakdown of hours for validation of experience.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

PROFESSIONAL ACCOUNTABILITY DECLARATION

Complete the declaration just prior to submitting your Summary of Clinical Competence for review.

I, _____ (candidate full name), attest to the following:

_____ (initial) I have no conflicts of interest* with any of my clinical advisors or delegated assessors.

_____ (initial) I performed** all procedures identified in the *Summary of Clinical Competence* independently, competently and consistently. All competencies were completed after registration into my certificate program in accordance to the SCC and program Handbook rules.

_____ (initial) I have performed** a minimum of 10 elective competencies, competently and consistently.

_____ (initial) All competencies were signed off under the direct supervision of a Clinical Advisor or Delegated Assessor **at the time** competency was achieved.

_____ (initial) I understand that any false or misleading statement, omission or misrepresentation may result in an automatic withdrawal from the program or revocation of the CTIC designation.

Date of first competency in SCC (DD MM YYYY): MUST FOLLOW CTIC REGISTRATION DATE

Date of last competency in SCC (DD MM YYYY): MUST BE BEFORE PROGRAM END DATE

_____ Signature of Candidate

MUST FOLLOW DATE OF LAST COMPETENCY
Date DD MM YYYY (no earlier than the final competency was met)

*Conflicts of interest may include:

- → Close personal relationships with CA or DA that could threaten independence or objectivity during assessments
- → Spouse or family member
- → A direct report (i.e. the assessor reports to the candidate)

** Performed = performed clinically as a certified MRT
Excludes simulation or observation, unless otherwise noted in the Summary of Clinical competence.

DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

DECLARATION OF COMPLETION

Complete the declaration just prior to submitting the Summary of Clinical Competence for review.

I certify that _____ (candidate name) has completed the Summary of Clinical Competence as per the requirements of the CT Imaging Certificate program.

I also attest that either myself or the delegated assessor have witnessed the candidate exhibit competent practice for each procedure/competency listed within this SCC. My signature verifies that the candidate has repeated each procedure/competency multiple times and has **consistently shown** that they have the knowledge, skill, and judgement to be deemed competent.

I understand that any false or misleading statement, omission or misrepresentation may result in a revocation of my CTIC designation (if applicable) and termination of my participation in CAMRT CPD.

Clinical Advisor Name: DO NOT USE THIS EXAMPLE, IT WILL NOT BE ACCEPTED

Clinical Advisor Signature: _____

Date (DD MM YYYY): THIS MUST BE THE LAST THING SIGNED IN THE SCC

PLEASE NOTE:

Candidates must submit the completed Summary of Clinical Competence to the CAMRT for review and approval by the CT Imaging Committee. Electronic copies submitted as one file will be accepted. Email to specialtycertificates@camrt.ca.

Summaries deemed incomplete will be subject to a resubmission fee, including outstanding didactic requirements. Refer to your Program Handbook to ensure all requirements have been met prior to submission.

Audits will be conducted at the discretion of the Committee to ensure proper procedures are being followed.