Republic of the Philippines
Department of Health
FOOD AND DRUG ADMINISTRATION
Filinvest Corporate City
Alabang, City of Muntinlupa

CHECKLIST OF REQUIREMENTS FOR THE ISSUANCE OF PRE-OPERATIONAL PERMIT OF A THERAPEUTIC X-RAY FACILITY

☐	1.	Duly accomplished application form (2 copies).
☐	2.	The design of the medical linear accelerator facility indicating shielding details duly evaluated and verified by a board certified radiation oncology medical physicist.
☐	3.	Technical description/specifications of the following equipment: a. Medical linear accelerator (linac) b. Treatment planning system c. Patient data management software if available d. Radiotherapy simulator or computed tomography simulator e. All other equipment listed in Appendix V of the AO No. 31 series 2013
☐	4.	Certification issued by the equipment manufacturer a. that the medical linac in its present condition is compliant with the performance and safety requirements of the International Atomic Energy Agency and the International Organization for Standardization/International Electrotechnical Commission (ISO/IEC). b. on the availability of spare parts, maintenance and repair services.
☐	5.	Notarized contract of employment between the facility and a. the radiation oncologist/s b. the certified radiation oncology medical physicist c. the radiation oncology medical physicist/s d. the four (4) radiologic technologists
☐	6.	Radiation Protection and Safety Program
☐	7.	Emergency procedures during testing, commissioning, internal and external quality audit and during clinical operation, including a system of reporting a radiological accident/incident.
☐	8.	Emergency preparedness and response plan in the event of radiological emergencies such as: a. Accident medical exposure of a patient b. Accident exposure of a worker c. Accident exposure of a member of the public
☐	9.	A certified true copy of the SEC/DTI registration

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Revision:	00

APPLICATION FORM FOR A PRE-OPERATIONAL PERMIT OF A THERAPEUTIC X-RAY FACILITY

General Instructions: Write legibly and in BLOCK letters. Put an "x" mark on appropriate tick box. Completely fill-up the required information and signatures. The CDRRHR will not receive and process unduly filled-up application forms. For requirements, please refer to the attached checklist.

I General Information

Name of Facility :_____
Facility Address :_____
_____
Contact No./s :_____

Name and Address of the Applicant, Legal Person, Company, Organization, etc.
Name :_____ Position/Designation :_____
Address : _____
Contact No./s:_____ Email Address : _____

II Name and qualifications of the personnel involved in the pre-operation of the facility

Radiation Oncologist

Name : _____
Qualification : ☐ FPROS ☐ DPBR-RO
PRC ID#/ Validity :_____
***SIGNATURE*:**

Certified Radiation Oncology Medical Physicist

Name :_____
Qualification:_____
***SIGNATURE*:**

III Proposed Radiation Therapy Services

☐ Conventional Radiation Therapy	☐ 3D Conformal Radiation Therapy	☐ Intensity Modulated Radiation Therapy
☐ Image Guided Radiation Therapy	☐ Stereotactic Radiosurgery and Radiotherapy	☐ Stereotactic Body Radiotherapy
☐ Total Body Irradiation	☐ Total Skin Electron Irradiation	☐ Intra-operative Radiotherapy
☐ Tomotherapy/Arc Therapy	☐ Adaptive Radiotherapy	☐ Respiratory Gated Radiotherapy
☐ Cyber Knife	☐ Others: Please specify: _____	

IV Tentative Facility Timeline

Construction Phase: _____
Installation Phase: _____
Acceptance and Commissioning: _____
Start of Clinical Operation: _____

III Declaration of the veracity of information: To be signed by the legal person/owner

I hereby declare that all the information provided on the form and in support of this application is to the best of my knowledge complete and true in every particular.

_____
Printed Name and Signature
Position:_____
Date: _____

For CDRRHR use

DTN No:
_____

☐ Thru mail
☐ Walk-in

Assessed by:
_____
*Date :*_____

Evaluated by:
_____
Date:_____

Status of the Facility:
_____
_____

Action taken :
_____
_____
_____
_____
_____
_____
_____
_____

Checked by:
_____
Date:_____

Printed by:
_____
Date:_____

Recommending Approval:
_____
Date:_____

Encoded by:
_____
Date:_____