



**American College of Surgeons**

**Stereotactic Breast Biopsy Accreditation Program  
Entry Application - Page 1**

Each physical location of one or more stereotactic breast biopsy units requires a separate application regardless of ownership. Type or print clearly and keep a copy of this application. Please answer all questions. *Do not submit an application if you do not meet all of the requirements specified in questions 2 through 7.* Your application must include (1) completed entry and verification form, (2) a signed survey agreement, (3) and the accreditation fee. **Incomplete applications will be returned.** Upon acceptance of this application by the ACS, a full application package with testing materials will be sent to you.

1. Facility name: \_\_\_\_\_ EIN: 

--	--	--	--	--	--	--	--	--	--

  
Street Address: \_\_\_\_\_  
\_\_\_\_\_  
City/Town: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
Contact person: \_\_\_\_\_ Contact telephone: (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

**You must meet all of the following requirements to apply. See instructions on page 3.**

2. Supervising physician's name: \_\_\_\_\_
3. Does the supervising physician meet the requirements as described on the verification form?       No       Yes
4. Do all technologists meet the requirements on page 3?       No       Yes
5. Do all medical physicists meet the requirements on page 3?       No       Yes
6. Do you have an annual medical physicist survey of each unit?       No       Yes
7. Does this facility collect outcome data for each of the required categories?       No       Yes

After completing the form, consult the remittance worksheet below, calculate your fee, and complete the following:

The application fee is. \$ \_\_\_\_\_       Check enclosed payable to ACS    OR     Charge credit card

Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_       VISA       MasterCard

Name of Cardholder: \_\_\_\_\_ Signature: \_\_\_\_\_

**Remittance Worksheet**

The fee for the first stereotactic unit at the facility is \$1600. Each additional unit after the first is \$1400.

First stereotactic unit	\$ _____
___ additional units @\$1400.00	+ \$ _____
Total Fee	\$ _____



**American College of Surgeons Stereotactic Breast Biopsy Accreditation Program  
Entry Application - Page 2**

1. Facility name: \_\_\_\_\_

Make copy of blank form for additional stereotactic biopsy and processing units.

**Describe the stereotactic unit(s) at this site. See unit code table on page 3.**

Unit 1: Manufacturer see instructions for code:    If other, specify manufacturer: \_\_\_\_\_

Model Name: \_\_\_\_\_ Serial Number: \_\_\_\_\_

Year Manufactured: \_\_\_\_\_

Type of unit:  Add-on  Prone table

Type of Recording System:  Screen-film  Digital

Unit 2: Manufacturer see instructions for code:    If other, specify manufacturer: \_\_\_\_\_

Model Name: \_\_\_\_\_ Serial Number: \_\_\_\_\_

Year Manufactured: \_\_\_\_\_

Type of unit:  Add-on  Prone table

Type of Recording System:  Screen-film  Digital

**Describe the processing unit(s) at this site (if applicable). See unit code table on page 3.  
For totally digital systems, no processing information is required.**

Processor 1: Processor Manufacturer see instructions for code:   If other, specify manufacturer: \_\_\_\_\_

Processor Model Name \_\_\_\_\_ Serial Number: \_\_\_\_\_

Processor 2: Processor Manufacturer see instructions for code:   If other, specify manufacturer: \_\_\_\_\_

Processor Model Name \_\_\_\_\_ Serial Number: \_\_\_\_\_

Check this box if this is the last page of the application

Mail your completed application to:  
Stereotactic Breast Biopsy Accreditation  
American College of Surgeons  
633 North Saint Clair Street  
Chicago, IL 60611  
ATTN: Connie Bura



**American College of Surgeons Stereotactic Breast Biopsy Accreditation Program Entry Application Instructions**

- 1. Facility name:** Enter the facility name as it should appear in all official correspondence and on the certification of accreditation. Be certain it appears on each page of this application.
- 2. Supervising physician:** Name of the official applicant for this facility who will be cited on all correspondence. He or she must meet requirements including (but not limited to) those listed on the verification form.

Requirements for Radiological Technologist and Medical Physicist		
	Radiological Technologist	Medical Physicist
Initial Credentialing	<ul style="list-style-type: none"> <li>• ARRT registered, <i>or</i></li> <li>• State licensure</li> </ul>	<ul style="list-style-type: none"> <li>• ABR certification, <i>or</i></li> <li>• ABMP certification, <i>or</i></li> <li>• State licensure, <i>or</i></li> <li>• State approval</li> </ul>
Initial Training	<ul style="list-style-type: none"> <li>• Performed at least 200 mammograms every 24 months</li> <li>• 3 Category A CEUs in stereotactic breast biopsy</li> </ul>	Have a master's degree or higher in a physical science with 20 hours of physics and 20 hours of training conducting surveys <i>or</i> if qualified under MQSA before 4/28/1999, have a BS in physical science with 10 hours of physics and 40 hours of training conducting surveys
Initial Experience	Performed 5 stereotactic breast biopsy procedures under supervision	<ul style="list-style-type: none"> <li>• 1 facility and 10 units, <i>or</i> if qualified before 4/28/99 with BS in physical science, 1 facility and 20 units</li> <li>• Performed 1 hands-on stereotactic breast biopsy survey under a qualified medical physicist</li> </ul>
Continuing Experience	<ul style="list-style-type: none"> <li>• 12 stereotactic breast biopsy exams per year</li> <li>• Perform at least 200 mammograms every 24 months</li> </ul>	Survey 1 stereotactic breast biopsy unit per year
Continuing Education	3 Category A CEUs in stereotactic breast biopsy every 3 years	3 CEUs in stereotactic breast biopsy every 3 years

**3. Requirements for outcome data collection:** Facilities applying for accreditation will be asked to submit specific data values for each of the following categories in the full application.

- |   |  |
|---|--|
| Total number of procedures                                  | Total number of benign lesions                       |
| Total number of cancers found                               | Total number of complications                        |
| Total number of stereotactic biopsies needing repeat biopsy | Complications: Hematoma requiring surgical attention |
| Repeat biopsies: Insufficient sample                        | Complications: Infection requiring treatment         |
| Repeat biopsies: Non-concordance with imaging               | Complications: Other                                 |
| Repeat biopsies: Ductal atypia, radial scar                 |  |
| Repeat biopsies: Other                                      |  |

**Stereotactic and Processing Unit Codes**

**Stereotactic Unit Manufacturers:** Please find the one code that identifies the manufacturer of the mammographic unit.

BEXR - Bennett	GEMS - General Electric	INRU - Instrumentarium	PICO - Picker	TREX - Trex Medical
CGRM - CGR Thompson	GEND - Gendex-Del	LRAD - Lorad	PLAN - Planmed	OTHR - Other (and specify)
DELM - Del Med Systems	GENX - General X-Ray	MOTI - Moti	SIEC - Siemens	
HGFC - Fischer	IMSC - IMS	PHMS - Philips	SORX - Soredex	

**Processor Manufacturers:** Please find the one code that identifies the manufacturer of the processor.

01-3M	04-AlphaTek	07-Ecomat	10-Kodak	13-Philips
02-AFP	05-Curix	08-Fuji	11-Konica	14-Picker
03-Agfa	06-DuPont	09-Hope	12-Pako	15-Vari-X
				99-Other (specify in space provided).

Upon acceptance of your application the ACS will send you instructions and bar-coded labels for submission of clinical images, the phantom images and a dosimeter. Copies of images are acceptable. **NOTE: It is assumed by the reviewers that the images submitted are examples of your best work.**



*Please print or type. List personnel for this facility. You may photocopy this form, if necessary. Return this list with your completed application.*

**Personnel Summary List**

**Physician**

*List each physician who performs stereotactic breast biopsies for this facility.*

Last name	First name	MI	Degree	Check box, if applicable
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application
_____	_____	_____	_____	<input type="checkbox"/> NEW since last application