

**ACCREDITATION**

**QUESTIONNAIRE**

**Medical Imaging Service Accreditation Programme**

**General Information**

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| 1.1 Name of accredited or applicant Organisation.  1.2 Please provide a brief summary of the primary function of the organisation and / or any changes in function during the past four years.           1.3 Briefing informationPlease check that the following documentation has been provided.[ ]  Completed Information Schedules one to three for each modality.[ ]  Copy of the current Quality Manual.[ ]  Copies of the contents pages of all manuals for each modality.[ ]  Copies of at least two documented examination procedures for each modality.[ ]  Copies of at least two typical examination reports for each modality. (Patient identity removed). Examples of amendments and/or subcontracted reports must also be included. ***Please note that in order to adequately brief the assessment team, it is necessary for IANZ to reproduce some or all of the material supplied.***1.4 Please identify the person who completed this submission.Name: Title: Signature: Date: 1.5 Please forward this submission and the documents listed above to:

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| **Return Address** |
|  | **IANZ**  |
| **Post** | Private Bag 28908RemueraAuckland 1541 |
|  |
|  |
| **Physical** | Building 7, Central Park, 660-670 Great South RoadEllerslieAuckland 1051 |
|  |
|  |
| **Telephone** | (09) 525 6655 |
| **Email** | info@ianz.govt.nz  |

Alternatively please liaise with the IANZ Coordination Officer to load information via the IANZ Portal. |

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| **INFORMATION SCHEDULE ONE - SERVICES OFFERED** |
| **PRACTICE:**  | **MODALITY:**  |
| **Examination Type:** | **Number/Month:** |
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| **INFORMATION SCHEDULE TWO - KEY PERSONNEL** |
| **PRACTICE:**  | **MODALITY:**  |
| **Name** | **Job Title** | **Summary of Qualifications and Experience:**Please also include details of Radiologist and nursing personnel where relevant |
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**Note:** Please identify the person or persons accepting responsibility for technical, clinical and quality matters.

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| **INFORMATION SCHEDULE THREE - KEY ITEMS OF EQUIPMENT** |
| **PRACTICE:**  | **MODALITY:**  |
| **Item** | **Installation Date** | **Summary of Calibration, QC and Servicing (including frequency):**Please include details of PAC/RIS where relevant |
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