

**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 information  Please 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:   |  |  | | --- | --- | | **Return Address** | | |  | **IANZ** | | **Post** | Private Bag 28908  Remuera  Auckland 1541 | |  | |  | | **Physical** | Level 1, 626 Great South Road  Ellerslie  Auckland 1051 | |  | |  | | **Telephone** | (09) 525 6655 | | **Facsimile** | (09) 525 2266 | | **Email** | [info@ianz.govt.nz](mailto: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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