

Place facility label here, if applicable

Place SBBAP barcode label here, if applicable

Facility Name: _____

Site #: _____

SBBAP ID no. _____

STEREOTACTIC BREAST BIOPSY ACCREDITATION PROGRAM MODALITY SECTION

Supervising Physician: _____

E-mail Address*: _____

Technologist Contact Person (contact person must be a technologist): _____

Contact Telephone: _____

E-mail Address*: _____

* Automatic status updates will be e-mailed to the facility throughout the accreditation process.

How many units are there at this location? enter a number _____

Stereotactic Breast Biopsy Practice Setting
(check one setting; see Program Requirements)
 Collaborative Independent

Describe the stereotactic unit(s) at this site.

Unit # _____ Room Location # _____
Manufacturer see code table _____
Model Name: _____ Serial Number: _____
Year Manufactured: _____
Place unit label here, if applicable

Date of last equipment evaluation/ physics survey: _____
If other, specify manufacturer: _____

Type of unit: 1 Add-on 2 Prone table Type of Recording System: 1 Screen-film 2 Digital

Is this unit new since your last accreditation? 1 No 2 Yes

Withdrawn: 1 No 2 Yes Date Inactivated: _____

Did this new unit replace an older one? 1 No 2 Yes Which unit does this replace? Model name: _____
Serial number: _____

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Manufacturer see code table _____
Model Name: _____ Serial Number: _____
Year Manufactured: _____
Place unit label here, if applicable

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To help us determine the most effective methods for communicating with the radiology community, please tell us how you heard about the Stereotactic Breast Biopsy Accreditation Program. Check all that apply

- Brochure mailing
- Web site (describe) _____
- Conference (name) _____
- Other (describe) _____
- ACR booth (name of meeting) _____
- Third party payer requirement (name of payer) _____
- State requirement