



1891 Preston White Drive, Reston, VA 20191-4397

**Mammography Accreditation Program
Entry Application – Page 2**

A "mammography unit" is defined as an x-ray unit/imaging receptor (e.g., screen-film or digital) system.

Facility name: _____

How many mammography units are there at this location? enter a number _____ Make copies of this page for additional mammography units.

Describe the mammography unit(s) at this site.

Is this a mobile unit (moves from the primary site to other sites)? ¹ No ² Yes, call the ACR for specific mobile accreditation instructions

Unit Room #: _____ ACR Unit #: _____

X-ray Unit Manufacturer (see code table in instructions): _____ If manufacturer code is not available, specify: _____

Model Name: _____ Unit Serial Number (check with service engineer if unsure): _____ Year Manufactured: _____

Type of recording system(s) used with this unit (check all that apply): Screen-film Full-field digital Computed radiography (CR)

Does this mammography unit meet equipment requirements described in FDA's Quality Mammography Standards; Final Rules? ¹ No ² Yes

Date of most recent medical physicist survey or a new mammography unit's Equipment Evaluation: (all items must pass) _____ / _____ / _____
mo day year

NEW UNITS ONLY: Submit the results of your medical physicist's Equipment Evaluation (that was performed no earlier than 6 months before the date on this application) before using this new mammography unit to examine patients. All deficient items must be corrected. To summarize the results, your medical physicist must complete the MQSA Requirements for Mammography Equipment checklist and the Medical Physicist's Mammography QC Test Summary form.

Is this a new mammography unit that has not undergone accreditation at this location? ¹ No ² Yes

Has this mammography unit moved here from a sister site? ¹ No ² Yes, MAP ID# _____

Did this new mammography unit replace an older one? ¹ No ² Yes, date removed from service: _____

(If yes, complete the section below to withdraw the unit. Have it signed by the lead interpreting physician, officer, or owner and return it with a copy of the unit's light blue ACR Mammography Accreditation certificate.)

MAP unit #	manufacturer	model	serial #	year mfr
print name			Lead Interpreting Physician	Facility Owner/Officer
title			signature	date signed

After completing the form, consult the enclosed remittance worksheet, calculate your fee, and complete the following. Payment **must** accompany the application.

The application fee is \$ _____ Check enclosed payable to ACR (Include MAP ID # on check) OR Credit card

Card No. _____ Exp. Date _____ VISA MasterCard American Express

Name of Cardholder: _____ Signature: _____

Mail your completed application to:

MAMMOGRAPHY ACCREDITATION PROGRAM
AMERICAN COLLEGE OF RADIOLOGY
1891 PRESTON WHITE DRIVE
RESTON, VA 20191-4397

For credit-card applications, FAX to:

(703) 648-9176

(Do not mail and fax the same application)