



WITHDRAWN UNIT MEMORANDUM

PRIVILEGED and CONFIDENTIAL • PEER REVIEW
Code of Virginia 8.01-581.17

DATE: \_\_\_\_\_

TO: [Facility Address Label]

FROM: \_\_\_\_\_
Staff, ACR Mammography Accreditation Program

SUBJECT: Verification of Withdrawn Mammography Units

The American College of Radiology Mammography Accreditation Program has been notified that your facility has permanently withdrawn the \_\_\_\_\_ mammography unit (#\_\_\_) from service at this location. Please confirm this as follows:

- Complete the information below and have your facility's supervising radiologist, president or CEO sign this letter (important, since this may impact reimbursement).
• Photocopy the light blue ACR Mammography Accreditation certificate for this unit (and remove the original from public display at your facility).
• Within ten business days of the date on this letter, fax this letter and the accreditation certificate to my attention at (703) 648-9176 or send them to the address below.

If you have NOT withdrawn this unit or if this was the only unit at the above location, call the ACR at (800) 227-6440 as soon as possible (but within ten business days) to notify us of your facility's intentions. If we do not hear from you, this memo will serve as written confirmation that your facility has withdrawn this unit from the ACR Mammography Accreditation Program and we will notify the FDA.

[ ] This unit was permanently withdrawn from performing mammography on: \_\_\_\_\_
(Complete one copy for each withdrawn unit. Return this letter after the unit is taken out of service.)

MAP Unit # Manufacturer Model Serial # Year Mfr
Supervising Radiologist Facility President/CEO
(print name) (circle one)
signature date signed