Introductory Memorandum

TO: Radiation Oncologist

FROM: Trudie Cushing, MS, RN, RTT, Manager
Radiation Oncology R-O PEER™ Program

SUBJECT: Radiation Oncology R-O PEER™ Program for Maintenance of Certification

The American College of Radiology is pleased to offer radiation oncologists the opportunity to fulfill Part Four: Assessment of Performance in Practice for the Maintenance of Certification (MOC) program for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation Program. This Practice Quality Improvement (PQI) program will not require the submission of any additional cases but does require that at least 2 cases per physician be reviewed during the on-site survey.

Following the survey, a final report and certificate of satisfactory completion of practice assessment will be issued to each participating radiation oncologist. If any recommended action measures are identified, the final report will request additional documentation that demonstrates that such measures have been appropriately addressed.

The application for R-O PEER™ is attached. When your site is applying for accreditation, you may include this application and the appropriate fee with the site's application.

If you would like additional information, please contact the Radiation Oncology R-O PEER™ Program at 1-800-770-0145 or e-mail at tcushing@acr.org

Original signatures are required on this form. Stamps or electronic signatures are unacceptable.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, Virginia 20191-4397

R-O PEER™ AGREEMENT

The undersigned hereby requests a review of his/her patient cases and relevant clinical documentation including but not limited to patient treatment records (charts), simulation films, port films, DRRs, isodose plans and any other treatment planning or patient information necessary to complete case reviews.

The purpose of this request is to fulfill the Practice Quality Improvement (PQI) component of Maintenance of Certification (MOC) for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation Program. The cost of the review will be paid for by:

Name of Participating Physician: ______________________________

Name and Address of Professional Corporation/Partnership: ______________________________

____

As a condition of receiving the requested review, I agree to:

1. ☐ Fee of $200.00 (ACR member) for review of patient cases for practice assessment during the Radiation Oncology Practice Accreditation Survey

   ☐ Fee of $ 300.00 (non-ACR member) for review of patient cases for practice assessment the during Radiation Oncology Practice Accreditation Survey

   The fee should be submitted to the ACR office with this signed agreement and the R-O PEER™ application components. Fees are not refundable.

2. Provide any necessary additional information requested by the review team including an improvement plan in response to recommendations and appropriate follow up data.

3. Receive the written final report and any peer review information.

The undersigned hereby releases and forever discharges the ACR, its directors, officers, members agents, volunteers, and employees from and against any and all claims, suits, damages, losses, expenses (including attorneys' fees) and liabilities by reason of, arising out of, or related to participation in the aforesaid review of the practice assessment of radiation oncology and the making of any report, statement, or recommendation, or failure to make a report, statement or recommendation, or the loss, damage or destruction of any image, record or other items received from the facility with respect to the aforesaid practice assessment of radiation oncology, including but not limited to any such claims or other matters based on alleged or actual negligence, antitrust, misconduct, defamation, personal injury or economic loss, catastrophic

event (flood, fire, wind or other similar event), failure to receive a satisfactory report or any actions that may be taken by others as a result of this review, when such activities performed by or on behalf of ACR are done in good faith and without malice in connection with conducting this review.

The undersigned also agrees that the ACR is a health care entity as defined by the Health Care
Quality Improvement Act of 1986 (HCQIA), and thus is afforded all the protections due such entities under HCQIA, and all documentation collected as part of the review process be considered peer review, privileged and confidential communications.

The above obligations are agreed to and understood. These obligations will survive the grant or denial of certificate of satisfactory completion of practice assessment by the American College of Radiology.

I certify that the information provided is true and correct.

Executed on ______________ 20_____ ____
Date Signature Radiation Oncologist

____
Printed Name Radiation Oncologist

The R-O PEER™ report will be issued to the above-signed Radiation Oncologist.

☐ **Check enclosed, made payable to ACR**

OR

Charge credit card ☐ VISA ☐ MasterCard ☐ American Express

Card No. ________________________________ **Exp. Date** _____________

Name of Cardholder:___________________________

Signature: __________________________________

Fax to
R-O PEER™ Program at 703-295-6776

or mail to
American College of Radiology
R-O PEER™ Program
1891 Preston White Drive
Reston VA 20191

For ACR office use only

Executed on___________20_________ ___________________________________
Date **ACR Program Manager, R-O PEER™**