Certification in Medical Physics SSRMP - Registration

Personal data:

Family name		First Name	
Gender	☐ male ☐ female not listed: ___________________		
Private Adress			
Academic Title		e-Mail	
Date of Birth		Place of origin (CH) or nationality	

If some of these coordinates are changing, please communicate to the education committee immediately!

Qualification/ Academic Degree:

Bachelor	Field: ___________________	University: ___________________
Master 1	Field: ___________________	University: ___________________
Master 2	Field: ___________________	University: ___________________

Qualification/ Certification in Medical Physics:

Certification	☐ No ☐ Yes, which: ___________________

Desired Certification:

Field	☐ **Radiation Physics**	☐ **Medical Imaging**
Specialisation	☐ Radiation Oncology	☐ Radio Diagnostics with X-rays
	☐ Radio Diagnostics	☐ Radio Diagnostics without X-rays
	☐ Nuclear Medicine	☐ Nuclear Medicine

Clinical Training Institution:

Institution	
Office Address	
Supervisor	
Working rate [hrs/week]	

Mentor:

Family name		First Name	
Institution			
Email address			
Mentor signature			

Attached documents

☐ CV	☐ University degrees	☐ Training plan or foreign certification

Return this completed form and the required documents to the chairperson of the education committee of SSRMP: chair.education@ssrmp.ch. For more information please visit:

https://ssrpm.ch/certification-for-medical-physicists/basic-information/

By signing, I register for education towards Certification in Medical Physics SSRMP.

Place/Date ___________________ **Signature** ___________________