

Member of the European Federation of Organisations for Medical Physics (EFOMP) and the International Organization for Medical Physics (IOMP)

## Certification in Medical Physics SSRMP - Registration

### Personal data:

Family name		First Name	
Gender	<input type="checkbox"/> male <input type="checkbox"/> female not listed: _____		
Private Address	_____		
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	<input type="checkbox"/> No <input type="checkbox"/> Yes, which: _____
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### Desired Certification:

Field	<input type="checkbox"/> <b>Radiation Physics</b>	<input type="checkbox"/> <b>Medical Imaging</b>
Specialisation	<input type="checkbox"/> Radiation Oncology	<input type="checkbox"/> Radio Diagnostics with X-rays
	<input type="checkbox"/> Radio Diagnostics	<input type="checkbox"/> Radio Diagnostics without X-rays
	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> 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

<input type="checkbox"/> CV	<input type="checkbox"/> University degrees	<input type="checkbox"/> Training plan or foreign certification
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Return this completed form and the required documents to [registration.education@ssrmp.ch](mailto:registration.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 \_\_\_\_\_