



## RTOG APPLICATION FOR MEMBERSHIP



RADIATION THERAPY ONCOLOGY GROUP  
AMERICAN COLLEGE OF RADIOLOGY  
1818 MARKET STREET, SUITE 1600  
PHILADELPHIA, PA 19103  
[WWW.RTOG.ORG](http://WWW.RTOG.ORG)

**RADIATION THERAPY ONCOLOGY GROUP  
APPLICATION FOR MEMBERSHIP**

Name of Institution \_\_\_\_\_

RTF# from RPC: \_\_\_\_\_ (available at RPC site: <http://rpc.mdanderson.org/rpc/index.asp>)

Address (street): \_\_\_\_\_

Address (city, state, zip): \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Has your institution ever been an RTOG member? \_\_\_\_\_ If so, when? \_\_\_\_\_

If so, please provide former RTOG # \_\_\_\_\_

**LIST ALL PHYSICIANS & KEY RESEARCH STAFF ON YOUR RTOG ROSTER SINCE THEY MUST BE CLAIMED BY RTOG ON CTSU REGULATORY SUPPORT SYSTEM (RSS) INCLUDE 1572, CV & NIH ETHIC CERTIFICATES FOR ALL PHYSICIANS & ETHIC CERTIFICATES FOR ALL STAFF AND CV/ETHICS CERTIFICATES FOR ALL PHYSICISTS:**

RTOG Principal Investigator: \_\_\_\_\_ NCI Investigator # \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Radiation Oncologist Co-Investigator: \_\_\_\_\_ NCI Investigator # \_\_\_\_\_

Physicist Co-Investigator: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Medical Oncologist Co-Investigator: \_\_\_\_\_ NCI Investigator # \_\_\_\_\_

Research Associate: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**ADDITIONAL STAFF:**

NAME & POSITION: \_\_\_\_\_

NAME & POSITION: \_\_\_\_\_

**ADDITIONAL STAFF (Continued)**

NAME & POSITION: \_\_\_\_\_

Is your facility capable of digital data exchange? \_\_\_\_\_ Yes \_\_\_\_\_ No

**EQUIPMENT** (Available for use in protocols)

(A) Megavoltage Treatment Machines

Type	Manufacturer	Serial #	X-Ray Energies	Electron Energies

\*Identify the machine if used for Intra-op \_\_\_\_\_

(B) Simulator

Manufacturer \_\_\_\_\_

Radiographic Only (yes/no) \_\_\_\_\_

Radiographic & Fluoro (yes/no) \_\_\_\_\_

SAD Range \_\_\_\_\_

(C) Other Dedicated Imaging Equipment Used for Localization in Planning Treatment

\_\_\_\_\_

(D) Treatment Planning Computer for External Beam (if more than one, list all)

Manufacturer \_\_\_\_\_ CPU \_\_\_\_\_

Software Name \_\_\_\_\_ Version \_\_\_\_\_

Algorithm for External Beam \_\_\_\_\_

Photons \_\_\_\_\_

Electrons \_\_\_\_\_

(E) Treatment Planning Computer for Brachytherapy (if more than one, list all)

Manufacturer \_\_\_\_\_ CPU \_\_\_\_\_

Software Name \_\_\_\_\_ Version \_\_\_\_\_

Algorithm for Brachytherapy \_\_\_\_\_

(F) Inventory of special procedures studied in RTOG protocols

1. Does your facility have a High Dose Rate Unit? If yes, please list the manufacturer.  
\_\_\_\_\_
2. Does your facility have stereotactic irradiation capabilities? If yes, please list:  
Machine \_\_\_\_\_ Frame \_\_\_\_\_  
Planning Software: Model \_\_\_\_\_ Version \_\_\_\_\_

**PHYSICS/DOSIMETRY EQUIPMENT**

(A) Institution's Standard Dosimeter for beam calibration: Photon\_\_\_\_\_ Electron\_\_\_\_\_

Type of Ion Chamber\_\_\_\_\_

Electrometer\_\_\_\_\_

Date of last NIST traceable calibration: Chamber: \_\_\_\_\_ Electrometer: \_\_\_\_\_  
(Submit Calibration Certificate)

(B) (i) Additional Ion Chamber Dosimeters (list) \_\_\_\_\_

\_\_\_\_\_

(ii) TLD/Diodes, etc. (list) \_\_\_\_\_

(C) Isodose Plotter/Water Phantom – Yes/No

Type \_\_\_\_\_

Manufacturer \_\_\_\_\_

Detector \_\_\_\_\_

(D) Film Densitometer

Type \_\_\_\_\_

Manufacturer \_\_\_\_\_

Detector \_\_\_\_\_

(E) Phantoms – (List)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(F) Does your institution have a method to calibrate brachytherapy sources?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**TREATMENT PLANNING**

1. (A) Depth dose, TAR, TMR, TPR, etc.  
Measured \_\_\_\_\_ Yes/No \_\_\_\_\_ Date \_\_\_\_\_  
Published Data \_\_\_\_\_ Yes/No \_\_\_\_\_ (Reference) \_\_\_\_\_  
(B) Wedge factors, tray factors, etc.  
Measured \_\_\_\_\_ Yes/No \_\_\_\_\_ (Date of Last Measurement) \_\_\_\_\_
2. Treatment time/monitor unit calculations  
Hand \_\_\_\_\_ Yes/No Computer \_\_\_\_\_ Yes/No \_\_\_\_\_
3. Multiple point dose calculations for irregular blocked fields.  
Hand \_\_\_\_\_ Yes/No Computer \_\_\_\_\_ Yes/No \_\_\_\_\_
4. Isodose Distributions  
Hand \_\_\_\_\_ Yes/No Single Plane \_\_\_\_\_ Yes/No \_\_\_\_\_  
Computer \_\_\_\_\_ Yes/No Multiple Planes \_\_\_\_\_ Yes/No \_\_\_\_\_
5. Brachytherapy  
Point Calculations \_\_\_\_\_ Yes/No Hand \_\_\_\_\_ Yes/No \_\_\_\_\_  
Isodose Distributions \_\_\_\_\_ Yes/No Computer \_\_\_\_\_ Yes/No \_\_\_\_\_

**TREATMENT RECORD**

1. Typically recorded daily doses  
Tumor \_\_\_\_\_ Yes/No \_\_\_\_\_  
dmax (give dose) \_\_\_\_\_ Yes/No \_\_\_\_\_  
Critical Organs (Specify) \_\_\_\_\_  
Other (Specify) \_\_\_\_\_
2. **ATTACH** sample copy of daily treatment record.



**CLINICAL MATERIAL**

Average number of NEW cancer patients seen in the hospital/institution per year. During the last calendar year, please indicate the following:

- Number of patients seen in consultation \_\_\_\_\_
- Number of patients treated \_\_\_\_\_
- Number of NEW patients treated \_\_\_\_\_
- Number of patients treated per day (Typical) \_\_\_\_\_
- Number of total fields treated per day (Typical) \_\_\_\_\_
- Percent of patients simulated \_\_\_\_\_
- Percent of patients having isodose distributions \_\_\_\_\_
- Percent of patients treated with individualized shaped fields \_\_\_\_\_
- Number of intracavitary insertions \_\_\_\_\_
- Number of interstitial implants \_\_\_\_\_
- Number of intra-op treatments \_\_\_\_\_
- Number of patients treated with external Hyperthermia \_\_\_\_\_
- Number of patients treated with interstitial Hyperthermia \_\_\_\_\_
- Is hemibody or total body irradiation administered (yes/no) \_\_\_\_\_

List approximate number of NEW patients per year in the following anatomical locations:

Brian	_____
Spinal Cord	_____
Nose, Paranasal Sinuses, Nasal Cavity	_____
Nasopharynx	_____
Oral Cavity (Gingiva, Floor of Mouth, Tonque)	_____
Oropharynx (Tonsil, Base of Tongue)	_____
Hypopharnx	_____
Larynx	_____
Other ENT Sites	_____
Skin	_____
Bronchus, Lung	_____
Esophagus	_____
Stomach	_____
Colon, Rectum, Sigmoid, Anal Canal	_____
Other Digestive Organs, Unspecified	_____
Peritoneum and Retroperitoneum	_____
Breast	_____
Ovary	_____
Cervix Uteri, Invasive	_____
Uterus	_____
Other Female Genital (Vagina, Vulva, etc.)	_____
Bladder	_____
Kidney, Pelvis of Kidney, Ureter	_____
Testis	_____
Prostate	_____
Other Male Genital	_____
Hodgkin's Disease	_____
Other Lymphomas	_____
Primary Bone and Joint	_____
Connective and Soft Tissue Sarcomas	_____
Other sites not specified above	_____
Benign	_____
% of patients treated for palliation	_____

Oncologic Team at Hospital (list names)

Medical \_\_\_\_\_

\_\_\_\_\_

Surgical \_\_\_\_\_

\_\_\_\_\_

Gynecology \_\_\_\_\_

\_\_\_\_\_

Head and Neck \_\_\_\_\_

\_\_\_\_\_

Pediatrics \_\_\_\_\_

\_\_\_\_\_

Urology \_\_\_\_\_

\_\_\_\_\_

Pathology \_\_\_\_\_

\_\_\_\_\_

Diagnostic Radiology \_\_\_\_\_

\_\_\_\_\_

Nuclear Medicine \_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

List participation in other National Cooperative Studies:

Group	Average # Patients Entered Per Year	# Patients Entered Into Studies in Previous Year	Of Those in Previous Year, % Evaluable	# Active Protocols Radiation Therapy

Does your institution have:?

A Tumor Registry? \_\_\_\_\_

A Social Service Department or Representative? \_\_\_\_\_

Pharmacy Participation in Investigational Drug Studies? \_\_\_\_\_

Does your institution have an Institutional Review Board? \_\_\_\_\_

Does your institution have an assurance document for human subjects that has been approved by the Office for Protection from Research Risks (OPRR), National Institutes of Health? \_\_\_\_\_ Yes/No

If yes, please indicate the type of assurance (multiple project or cooperative project) & assurance #.

Type \_\_\_\_\_ Number \_\_\_\_\_

FOLLOW-UP

Are patients treated by radiation therapy with curative intent followed by the radiation oncologist subsequent to completion of treatment? \_\_\_\_\_

General duration of this follow-up \_\_\_\_\_

If not followed by radiation oncologist, clarify mechanism for follow-up \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How do you plan to perform data management at your institution? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

GENERAL

1. Does your department have a Residency Training Program in Therapeutic Radiology?  
\_\_\_\_\_ Yes/No If Yes, Total # Residents \_\_\_\_\_

Number/Year \_\_\_\_\_

2. Number of weekly intra-departmental conferences \_\_\_\_\_

3. Number of weekly inter-departmental clinics/conferences \_\_\_\_\_

4. Number of hospital beds for radiation therapy patients \_\_\_\_\_

5. List any unique features of your program of potential value to RTOG:

6. Remarks:

If approved, when would you like your membership to become effective? \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Radiation Oncologist \_\_\_\_\_

Name of Radiation Oncologist \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Institutional Official \_\_\_\_\_

Name of Institutional Official \_\_\_\_\_

**APPLICANT: PLEASE FORWARD THIS APPLICATION AND ALL ATTACHMENTS TO THE RTOG FULL MEMBER WHO HAS AGREED TO SERVE AS YOUR PARENT INSTITUTION.**

**FULL MEMBER INSTITUTION REVIEW**

**Reviewed and approved:**

Date: \_\_\_\_\_ Signature of Full Member PI \_\_\_\_\_

Name of Full Member PI \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Full Member Physicist \_\_\_\_\_

Name of Full Member Physicist \_\_\_\_\_

**FULL MEMBER INSTITUTION (RTOG INSTITUTION # \_\_\_\_\_)**

**PLEASE FORWARD ENTIRE APPLICATION TO:**

*Linda M. Bomba  
American College of Radiology  
Radiation Therapy Oncology Group  
1818 Market Street, Suite 1600  
Philadelphia, PA 19103  
Revised: 07/20/04*

RTOG USE ONLY	YES	NO	
FEE PAID	<input type="checkbox"/>	<input type="checkbox"/>	DATE: _____
MEMBERSHIP TYPE	AFFILIATE	JOINT CENTER	CCOP FULL PROVISIONAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>