



Reporting Program and/or Personnel Changes

Complete this form, print it, add supporting documents then mail, email or fax to JRCNMT for processing. Please check the appropriate box(es) to indicate the type of change requested and provide the necessary explanation in the comment section.

FROM:

TITLE:

PROGRAM:

CITY/STATE:

DATE:

EMAIL:

PROGRAM CHANGES

Please check the appropriate boxes to indicate who this request pertains to and the type of change requested. Provide rationale in comment section.

WHO	TYPE OF CHANGE		
<input type="checkbox"/> ACADEMIC AFFILIATE	<input type="checkbox"/> ADDRESS	<input type="checkbox"/>	<input type="checkbox"/> TELEPHONE NUMBER
<input type="checkbox"/> CLINICAL AFFILIATE	<input type="checkbox"/> EMAIL ADDRESS	<input type="checkbox"/>	<input type="checkbox"/> INSTITUTION NAME
<input type="checkbox"/> PROGRAM	<input type="checkbox"/> FAX NUMBER	<input type="checkbox"/>	<input type="checkbox"/> DELETE AFFILIATE
<input type="checkbox"/> OTHER (explain below)	<input type="checkbox"/> DECREASE AFFILIATE CAPACITY	<input type="checkbox"/>	<input type="checkbox"/> OTHER (EXPLAIN BELOW)
	<input type="checkbox"/> INCREASE STUDENT CAPACITY (Explain why and provide forms CLB through CLE)		

PERSONNEL CHANGES

If position is filled with an interim indicate as such and provide CV and proof of board certification. If position is vacant, describe process being taken to fill position and actions taken to maintain program continuity and effectiveness in the interim.

TYPE OF CHANGE
<input type="checkbox"/> PROGRAM DIRECTOR (Provide CV form & proof of board certification)
<input type="checkbox"/> PROGRAM CLINICAL COORDINATOR (Provide CV form & proof of board certification)
<input type="checkbox"/> MEDICAL DIRECTOR (Provide CV form, proof of board certification & authorized user status)
<input type="checkbox"/> AFFILIATE CLINICAL SUPERVISOR (Provide proof of board certification)
<input type="checkbox"/> AFFILIATE MEDICAL DIRECTOR (Provide proof of board certification & authorized user status)
<input type="checkbox"/> ACADEMIC AFFILIATE NUCLEAR MEDICINE ADVISOR (Provide CV form)
<input type="checkbox"/> OTHER (Explain below and provide appropriate documentation)
<p>Sponsor or Affiliate:</p> <p>Previous person in position (include degrees and certifications):</p> <p>New person in position (include degrees and certifications):</p> <p>Contact Information:</p>