8892 Beckett Road
West Chester, OH 45069
(FAX) 866-740-9957
(PHONE) 866-301-4045

Name: _____

MRI Skills Check List- Please indicate number of years/ months of experience.

MRI PROCEDURES	CODE	YRS.	MOS.
Gradient Echo Imaging	PCU		
Angio	PTX		
Injections	PTW		
Multiplanar Reconstruction	PCV		
Partial Saturation Images	PXX		
Perfusion & Diffusion	PXI		
Spin-Echo Images	PXK		
Surface Coils	PCW		
T-1 Weighted Images	PXL		
T-2 Weighted Images	PXM		
Use of Contrast	PCX		

EQUIPMENT	CODE	YRS.	MOS.
Diasonics	EIH		

BACKGROUND	CODE	YRS.	MOS.
Applications	BAG		
Clinics	BAD		
Doctor's Office	BAB		
Hospital	BAA		
Management Exp.	BAE		
Mobile Route	BRG		
Teach/ Educational	BAF		

TITLE/ POSITION	CODE	YRS.	MOS.
Director	M*B		
Non Reg. MRI	TRG		
Registered MRI	TRD		
Reg. Eligible	TRB		
Supervisor/ Lead	M*A		

***I certify that the above information is a true representation of my abilities.

Signature: _____ **Date:** _____