



SCOPE OF SERVICES  
Radiation Oncology

Last Name	First Name	Middle Name
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Check appropriate box indicating which clinical capabilities you are willing and able to perform

**Please list any limitations on a separate sheet**

Radiation Oncology		
<input type="checkbox"/>	External Beam Therapy (EBT)	<input type="checkbox"/>
<input type="checkbox"/>	Image Guided Radiation Therapy (IGRT)	<input type="checkbox"/>
<input type="checkbox"/>	Intensity Modulated Radiation Therapy (IMRT)	<input type="checkbox"/>
<input type="checkbox"/>	3-D Conformal Radiotherapy	<input type="checkbox"/>
<input type="checkbox"/>	CT Simulation and experience with several treatment planning software systems	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	Skin - with Electrons and Photons	<input type="checkbox"/>
<input type="checkbox"/>	Head	<input type="checkbox"/>
<input type="checkbox"/>	Neck	<input type="checkbox"/>
<input type="checkbox"/>	Chest	<input type="checkbox"/>
<input type="checkbox"/>	Abdomen / GI	<input type="checkbox"/>
<input type="checkbox"/>	Pelvis	<input type="checkbox"/>
<input type="checkbox"/>	Lymphomas	<input type="checkbox"/>
<input type="checkbox"/>	Soft Tissue Sarcomas	<input type="checkbox"/>
<input type="checkbox"/>	Multiple Myeloma / Pasmacytomas	<input type="checkbox"/>
<input type="checkbox"/>	Bone	<input type="checkbox"/>
<input type="checkbox"/>	Pediatric Oncology	<input type="checkbox"/>

**Signing below indicates that I am qualified to perform the services chosen on the checklist**

Signature
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Date
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