CERTIFICATE RESPECTING CLINICAL PRACTICE – DIAGNOSTIC MEDICAL SONOGRAPHY

List all the diagnostic medical sonography procedures you have performed independently in your employment as a medical radiation technologist in the specialty of diagnostic medical sonography, the frequency each procedure was performed and the date on which each of the procedures was last performed.

Procedures:	Date last performed	Frequency that procedure was performed: Less than once per month	1-20 times per month	over 20 times per month
General				
Obstetrics				
Female pelvis				
Male pelvis				
Abdomen/retroperitoneum				
Chest (excludes cardiac)				
Breast				
Thyroid/neck/parathyroid				
Scrotum/testicles/penis				
Superficial (soft tissue) structures				
Shoulder				
Elbow				
Wrist				
Hand/fingers				
Hip				
Knee				
Ankle				
Foot/toes				
Vascular				
Extracranial arteries (carotid/vertebral/subclavian arteries)				
Upper extremity peripheral veins (for DVT)				
Lower extremity peripheral veins (for DVT)				
Abdominal vasculature (arterial and venous studies)				
Upper extremity (arterial and venous studies)				
Lower extremity (arterial and venous studies)				
Photoplethysmography				
Arterial pressure testing				
Vascular exercise testing				
Cardiac				
Paediatric heart				
Adult heart				
Stress echocardiography				
Other				
Infection control procedures				
Transducer cleaning and reprocessing procedures				
Equipment quality control				
Insertion of transvaginal transducer				
Insertion of transrectal transducer				
Administer contrast media by injection				

Applicant's validation of competence

"I hereby certify that I have been trained to perform, am competent to perform and performed in my employment the specific procedures set out above, within the time frame indicated".
"I give permission to the CMRTO to contact any authority or association in any jurisdiction to verify the above statements"

Applicant's Signature	Date Signed: (dd/mm/yyyy)

Supervisor's validation of applicant's competence

"I hereby certify that the applicant has competently performed all of the specific procedures listed above, that all the information contained in the above list of procedures and certificate is true and correct and that I am/was the direct clinical supervisor of the applicant. I hereby acknowledge that the College of Medical Radiation Technologists of Ontario will be relying upon this validation as evidence of the applicant's competent clinical practice in the specialty within the last five years."

Supervisor Name	Supervisor Title
Telephone of Supevisor:	Email of Supervisor:
Supervisor Signature	Date Signed: (dd/mm/yyyy)

Stamp or seal of facility