



**Radiation Oncology Facility Survey**

The Quality Assurance Review Center (QARC) is a Data and Review Center, providing radiotherapy quality assurance and diagnostic imaging data management programs for several NCI supported Cooperative Groups and international pharmaceutical companies. QARC is an established research resource for clinical investigators around the world.

**In an effort to maintain up-to-date records, please complete the Radiation Facility information below. Your time is appreciated.**

Submit Survey to:

QARC  
Suite 201, 640 George Washington Highway  
Lincoln, RI 02865-4207  
Phone: 401-753-7600 Fax: 401-753-7601

Individual Completing Survey:

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Cooperative Group:** \_\_\_\_\_

**Name of Radiation Oncology Facility:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Country:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Is this Facility also known by any other name? If so, please provide:** \_\_\_\_\_

\_\_\_\_\_

**Mailing Address** (if different from above): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name of Registering/ Referring Institution(s) / Cooperative Group:** \_\_\_\_\_

\_\_\_\_\_

**Responsible Radiation Oncologist:**

**Name:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Radiotherapy Coordinator- Primary Contact in Radiation Oncology** (The person within RT who will triage questions):

**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other Radiation Oncologists Who May Be Treating Patients:**

**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Physicist Responsible for Protocol Compliance:**

**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Person Responsible for Protocol Patients Dosimetry:**

**Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Does this site participate in the Radiological Physics Center's (RPC) Thermoluminescent Dosimetry (TLD) survey program (required)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last survey: \_\_\_\_\_

For questions regarding this form contact [GOSagie@QARC.org](mailto:GOSagie@QARC.org)