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# Radiation Safety Course - Student FMX Sign-Off Form (Doctor to Complete)

## Student Information

Full Name : _____ Date of Birth : _____

Class Date : _____ Dates of FMX taken : _____

## Doctor Information

Full Name : _____ License Number : _____

Office Name : _____

Office Address : _____

Office Phone Number : _____ Email Address : _____

I _____ hereby certify that I personally supervised or reviewed the radio graphs (1 FMX for Patient - 2 Patients in total )and confirm that the student listed above performed the FMX exposure independently.

**Student Signature**

**Doctor Signature**

**Student Full Name :** _____

**Date :** _____

**Doctor Full Name :** _____

**Date :** _____

**Please attach the two Patients FMX to this form and Bring it in Person**