UNIVERSITY OF IOWA HOSPITALS & CLINICS
APPLICATION FOR CLINICAL USE OF COMPOUNDED RADIOPHARMACEUTICALS

APPLICATION # _____
(Assigned by EHS)

ITEM 1: RADIOPHARMACEUTICAL:
(List generic and common chemical name)

ITEM 2: DESCRIPTION OF CLINICAL USE:
(Attach a copy of the drug use monograph listed in the United States Pharmacopeia Dispensing Information (USP-DI) or describe all applicable drug use information in detail.)

ITEM 3: PRODUCT SPECIFICATIONS:
(Attach a copy of the drug standards monograph from the United States Pharmacopeia or describe all applicable drug standard information in detail.)

ITEM 4: AUTHORIZED USER:
(*List name of the specific individual or for general authorized use check box below.)*

☐ *Physicians holding University of Iowa Hospital Staff privileges in Nuclear Medicine, Radiology, or Radiation Oncology appropriate to the diagnostic and therapeutic use of radiopharmaceuticals, whose credentials and qualifications have been approved by the University of Iowa Hospital Radiation Safety Review Group. (Under this general approval the Certification Statement below requires the signature of the Division or Department Head.)*

ITEM 5: RADIATION SAFETY PROCEDURES:
(Provide general description of procedures to meet regulatory and policy requirements)

ITEM 6: CERTIFICATION STATEMENT:

This is to certify that the compounded radiopharmaceutical agent in question (Item 1) will be used for routine clinical use as described (Item 2) by the authorized user(s) specified (Item 4). All usage shall be in accordance with the radiation safety procedures described (Item 5) and other applicable University, state and federal policies and regulations.

_____ _____
Signature (*Authorized User/Division or Dept. Head)* Date

_____ _____
Typed Name Title