Quality Assurance or Digital Imaging

FORM 04

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

Unit or Equipment ID: _____ **Procedure or Limits Reference:** _____

Follow manufacturer protocols and applicable test frequencies. Use dedicated CT, mammography, or therapy forms as needed.

Date	Check Performed	Measured Result or Units	Action or Follow-Up Reference	Initials

Quality Assurance or Digital Imaging

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

Record supporting references, review, and applicable requirements below.

Note(s) or Supporting Record(s):

Reviewed By: _____ **Review Date:** _____

State or Jurisdiction: _____

Regulatory Requirement Reference(s): _____

Required Interval(s) or Deadline(s): _____

Retention(s) or Trigger(s): _____