

**MRI TRAINING SURVEY**  
2002 ACR RESIDENT PHYSICIAN SECTION

*Please answer the following questions regarding your MR training experience.*

*Please return completed surveys to the attention of Kelly Foster at the ACR  
via fax – 703.262.9319  
via post – 1891 Preston White Dr, Reston VA, 20191*

**1. What type of residency program are you in? (Check the best response.)**

Diagnostic radiology

Radiation oncology

**2. What year of training are you in? \_\_\_\_\_**

**3. How many residents are in your program? \_\_\_\_\_**

**4. How many MRI Scanners are in your facility? \_\_\_\_\_**

**5. How many staff does your department have? \_\_\_\_\_**

**6. Rate the overall adequacy of your residency training in MR as it pertains to your feeling prepared for practice after residency.**

*(Check the best response.)*

Less than adequate

Adequate

More than adequate

*Additional comments:* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. Do you have a dedicated rotation in Neuro MRI? (Check the best answer.)

YES

If YES, how many total months will you train? \_\_\_\_\_

If YES, how many cases per week do you see? \_\_\_\_ per/week

NO

If NO, when do you receive training? (Please describe in the space provided.)

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8. Do you have a dedicated rotation in MSK MRI? (Check the best answer.)

YES

If YES, how many total months will you train? \_\_\_\_\_

If YES, how many cases per week do you see? \_\_\_\_ per/week

NO

If NO, when do you receive training? (Please describe in the space provided.)

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9. Do you have a dedicated rotation in Body MRI? (Check the best answer.)

YES

If YES, how many total months will you train? \_\_\_\_\_

If YES, how many cases per week do you see? \_\_\_\_ per/week

NO

If NO, when do you receive training? (Please describe in the space provided.)

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**10. Do you receive any formal teaching in MRI physics?**

YES

NO

*Additional comments:* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**11. Would you like to see a MRI minimum training requirement for residency training?**

YES

NO

*Additional comments:* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**12. Minimum training requirements require quantifying training in terms of either time spent or cases seen. Please indicate which method you prefer with regard to MRI training?**

Time spent

Cases seen

No preference

Other (*Please explain.*) \_\_\_\_\_

\_\_\_\_\_

*Thank you for completing the survey.*

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