RADIATION PROTECTION SECTION

Division of Health Service Regulation ● N.C. Department of Health and Human Services

BUSINESS APPLICATION FOR REGISTRATION

(This form is for all X-Ray Registrants and Service Providers)

☐ New Facility Registration Internal Use Only #: _____

☐ Move to New Location: Current Registration #: _____

☐ Change of Ownership: *Previous Registrants Name*: _____ *Previous Registration #:* _____

ANY CHANGES TO AN EXISTING REGISTRATION SHOULD BE MADE ON THE FACILITY'S NOTIFICATION OF REGISTRATION

1. BUSINESS INFORMATION: *Location of the business and units, each physical address requires a separate registration listing all of the units at the location.*

Legal Business Name: _____

Physical Address: _____ Phone: _____ Ext: _____

City: _____ State: _____ Zip Code+4 _____ County: _____

Type of Business: ☐ Chiropractic ☐ Dental ☐ Education ☐ Health Dept ☐ Hospital ☐ Imaging Center ☐ Physician ☐ Therapy ☐ Veterinary ☐ Government (State) ☐ Government (Federal) ☐ Industrial / Analytical ☐ Service Provider

MOST RESPONSIBLE PERSON AT BUSINESS LOCATION (Required if different from most responsible person at #4 below): *Person such as the director of imaging or office administrator at the facility who might be delegated responsibilities such as making major decision regarding corrective action and general operations and purchasing equipment.*

Name of Contact: _____ Title or Position: _____ Phone: _____ Ext: _____

2. MAILING CONTACT (Required if different from most responsible person at #4 below): *Person such as the director of imaging or office administrator at the facility who might be delegated responsibilities such as making major decision regarding corrective action and general operations and purchasing equipment.*

Name of Contact: _____ Title or Position: _____

Mailing Address: _____ Phone: _____ _____ Ext: _____

City: _____ State: _____ Zip Code + 4 _____ Email: _____

3. BILLING CONTACT INFORMATION (Required if different from most responsible person at #4 below): *Person with authority to pay annual invoice.*

Name of Contact: _____ Title or Position: _____

Billing Address: _____ Phone: _____ Ext: _____

City: _____ State: _____ Zip Code + 4 _____ Email: _____

4. MOST RESPONSIBLE PERSON / CORPORATION (Required): *Person who is the financial owner such as Physician, CEO, or corporate officer.*

Corporate Name: _____

Name of Most Responsible Person: _____ Title or Position: _____

Address: _____ Phone: _____ Ext: _____

City: _____ State: _____ Zip Code + 4 _____ Email: _____

Type of Ownership: Individual(s) ☐ Limited Partnership ☐ General Partnership ☐ Corporation ☐ LLC ☐ PA ☐ PC ☐

5. Individual Responsible for Radiation Protection (Required):

Documentation of training and experience for person designated for radiation protection must to be available for agency review.

Name of Most Responsible Person: _____ Title or Position: _____

Address: _____ Phone: _____ Ext: _____

City: _____ State: _____ Zip Code + 4 _____ Email: _____

6. Equipment Registration Forms: Check Each Form Included with This Application**:**

Note: A business may require more than one equipment form to include all equipment

☐ Healing Arts (Human / Animal use) ☐ Non-Healing Arts (Non-Human use) ☐ Dental ☐ Mammography ☐ Delete Units ☐ Service Provider

7. THE LEGAL OWNER OR RADIATION PROTECTION REPRESENTATIVE OR AUTHORIZED DESIGNEE MUST SIGN AND CERTIFY ALL INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE:

Date: _____ Print Name: _____ Signature: _____ Title: _____

6. General Statue 104E-7 (4) requires registration of x-ray machines and facilities providing x-ray services. List all x-ray machines for the initial registration. When adding, deleting or storing a specific machine, list only the affected machine(s). Registration fees are due upon date of issuance of registration and annually thereafter on July 1 in accordance with 15A NCAC 11.1102.

LIST ALL X-RAY UNITS USE CONTROL CONSOLE INFORMATION

Check appropriate boxes for each x-ray unit

Mammography Units use Addendum

Room Number	Manufacturer	Model Number/Name	Control Serial Number	No. of Tubes	Date Control Console was Installed	Type of Install: First Install This Location	Type of Install: Replacement	Type of Install: Relocation of Existing Unit	SELECT TYPE if applicable: MOBILE	SELECT TYPE if applicable: DIGITAL	SELECT TYPE if applicable: HAND-HELD (prior approval required)	GENERAL: RADIOGRAPHIC	GENERAL: FLUOROSCOPIC	GENERAL: CT SCANNER	GENERAL: C-ARM	GENERAL: BONE DENSITY	GENERAL: THERAPY	DENTAL: INTRAORAL	DENTAL: PANORAMIC	DENTAL: CEPHALOMETRIC	DENTAL: CONE BEAM CT
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7. LIST Deleted Units ☐ Taken by Service Company ☐ Salvaged ☐ Sent to Land Fill ☐ Sold or Donated ☐ Out of State

8. LIST Not In Use Units – Effective July 1, 2006 **Stored X-ray Facilities** will be subject to the Annual Fee.

9. Please list recipient of sold, deleted or donated x-ray units:

Individual/Business ______________________________ Phone Number: (____)____________ Fax Number (____) _________

City:___________________ State: ____ Zip Code + 4 _________ Email ____

10. Installer Information or Previously Installed For ___________________ **(Old Registration)**

Business Name ________________________________ Phone Number: (____)______ Email _____

Address____ City:__________________ State: ____ Zip Code + 4 ______

11. THE LEGAL OWNER OR RADIATION PROTECTION REPRESENTATIVE OR AUTHORIZED DESIGNEE MUST SIGN AND CERTIFY ALL INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE:

Date:______________Signature: ________________________ Print Name:____________________ Title: ___________________

__________ Inspector Initial _______________ Date ☐ Accept ☐ Accept with Change ☐ Reject

REGNO: **FDA CERTIFICATE NAME** **MAMMOGRAPHY UNITS ONLY**

M7. ____

LIST MAMMOGRAPHY UNITS USE CONTROL CONSOLE INFORMATION

Registration fees are due upon date of issuance of registration and annually thereafter on July 1 in accordance with 15A NCAC 11.1102.

Check all boxes that apply for each machine
Identify P or NP for all Non Certified Equipment
P = Patient / NP = Non Patient

									FDA Certified						STEREO			Non Certified				
Room Number	Manufacturer	Model Name	FDA #	CONTROL Serial Number	Date of MFG	No. of Tubes	Date Control Console was Installed	ADDING UNIT	FILM SCREEN	DIGITAL DR	COMPUTED RAD - CR	MOBILE	TOMOSYNTHESIS	STEREO ATTACHMENT	STEREOTATIC	STEREOTATIC MOBILE	ACCREITED BY ACR	BIOSPY/LOC P ☐ NP ☐	SPECIMEN CABINET- NP	EDUCATION P ☐ NP ☐	RESEARCH P ☐ NP ☐	VET - NP
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M8. LIST Deleted Units ☐ Taken by Service Company ☐ Salvaged ☐ Sent to Land Fill ☐ Donated ☐ Out of State ☐ Made Permanently Inoperable

M9. LIST Units NOT In USE – Not in Use units will be subject to the Annual Fees.

M10. Please list recipient of sold, deleted or donated x-ray units:

Individual/Business ______________________________ Phone Number: (____)____________ Fax Number (____)________________

City:______________________________ State: ____ Zip Code + 4 ________________ Email ________________________

THE RADIATION SAFETY OFFICER OR PERSON RESPONSIBLE FOR RADIATION AT YOUR FACILITY MUST BE IDENTIFIED IN YOUR RADIATION PROTECTION PROGRAM.

M11. THE LEGAL OWNER OR RADIATION PROTECTION REPRESENTATIVE OR AUTHORIZED DESIGNEE MUST SIGN AND CERTIFY ALL INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE:

Date:______________ Signature: ____________________________ Print Name:_______________________ Title: _______________________

________ Inspector Initials ___________ Date ☐Accept ☐ Accept with Changes ☐Reject