RADIATION PROTECTION SECTION

Division of Health Service Regulation ● NC Department of Health and Human Services

APPLICATION FOR REGISTRATION OF RADIATION UNITS AND FACILITIES
NON-HEALING ARTS

☐ Initial Registration ☐ New Satellite Office ☐ Amended Registration ☐ We've moved
☐ Change of Ownership ☐ Name change Reg. No_____

1. FACILITY INFORMATION (Required): Location of the facility & x-ray units, each physical address requires a separate registration listing all of the units at the location.

Name of Facility: _____ Phone: (_____) _____

Physical Address: _____ Fax: (_____) _____

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

Type of Facility: ☐ Education ☐ Government ☐ Hospital ☐ Industrial ☐ Mobile Service ☐ Other

2. FACILITY 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 equipments.

Name of Facility Contact: _____ Title or Position: _____

Mailing Address: _____ Phone: (_____)_____

City: _____ State: _____ Zip Code + 4 _____ Fax: (_____)_____

Email: _____

3. BILLING or ACCOUNTING SPECIALIST (Required): Person with authority to pay annual invoice.

Name of Contact: _____ Title or Position: _____

Billing Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip Code + 4 _____ Fax: (_____)_____

Email: _____

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

Corporate Name: _____ Email: _____

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

Address: _____ Phone: (_____)_____

City: _____ State: ____ Zip Code + 4 _____ Fax: (_____) _____

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

5. INSTALLER INFORMATION or *PREVIOUSLY INSTALLED FOR*: _____
Old Registration

Business Name: _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip Code: _____

6. The provisions of 15A NCAC 11 .0203, requires registration of x-ray facilities and each radiation machine within 30 days following initial operation of the facility and each radiation machine. 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 box for each x-ray unit**													
Room Number	**Manufacturer**	**Model Number/Name**	**Control Serial Number**	**No. of Tubes**	**Date Control Console was Installed**	ADD THIS MACHINE	CABINET RADIOGRAPHY	SHIELDED ROOM RADIOGRAPHY	OTHER INDUSTRIAL RADIOGRAPHY	DIFFRACTION	SPECTROSCOPY	ELECTRON MICROSCOPE	PROCESS CONTROL GAUGE	NON-HUMAN USE DENTAL	NON-HUMAN USE MEDICAL	PERSONNEL SCREENING SECURITY	MAIL / BAGGAGE SCREENING	HOME LAND SECURITY	OTHER (SPECIFY)
						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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7. LIST Deleted Units ☐ Taken by Service Company ☐ Salvaged ☐ Sent to Land Fill ☐ Donated ☐ Out of State ☐ Made Permanently Inoperable

8. LIST Units NOT in Use – Not in Use units are subject to the Annual Fees.

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

Individual/Business Name:______________________________ Phone Number: (____) __________ Fax Number: (___) (_____)____________

City:__________________________ State: _____ Zip Code + 4 _______ Email: ____

10. Radiation Safety Officer (Required): Documentation(s) of RSO's training and experience must to be available for agency review.

Name of Contact ____ Phone Number: (____)____________ Fax Number (____)_______________

City:__________________________ State: ____ Zip Code + 4 _______ Email ____

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 Initials ___________ Date ☐Accept ☐ Accept with Changes ☐Reject