# APPLICATION FOR REGISTRATION OF RADIATION UNITS AND FACILITIES

## HEALING ARTS

<table>
<thead>
<tr>
<th>Initial Registration</th>
<th>New Satellite Office</th>
<th>Amended Registration</th>
<th>We’ve moved</th>
<th>Change of Ownership</th>
<th>Name change</th>
<th>Reg. No</th>
</tr>
</thead>
</table>

### 1. FACILITY INFORMATION (Required)

Name of Facility: ____________________________

Phone: (_____) ____________________________

Physical Address: ____________________________

Fax: (_____) ____________________________

City: __________ County: __________ State: ___ Zip Code + 4 __________

Type of Facility:

- [ ] Chiropractic
- [ ] Dental
- [ ] Education
- [ ] Government
- [ ] Health Dept
- [ ] Imaging Center
- [ ] Hospital
- [ ] Clinic
- [ ] Physician
- [ ] Podiatry
- [ ] Veterinary
- [ ] Therapy
- [ ] Mobile Service

### 2. FACILITY CONTACT (Required if different from most responsible person at #4 below)

Name of Facility Contact: ____________________________

Title or Position: ____________________________

Mailing Address: ____________________________

Phone: (_____) ____________________________

City: __________ State: ___ Zip Code + 4 __________

Fax: (_____) ____________________________

### 3. BILLING or ACCOUNTING SPECIALIST (Required)

Name of Contact: ____________________________

Title or Position: ____________________________

Billing Address: ____________________________

Phone: (_____) ____________________________

City: __________ State: ___ Zip Code + 4 __________

Fax: (_____) ____________________________

Email: ____________________________

### 4. MOST RESPONSIBLE PERSON / CORPORATION (Required)

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: __________
7. 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**

<table>
<thead>
<tr>
<th>Room Number</th>
<th>Manufacturer</th>
<th>Model Number/Name</th>
<th>Control Serial Number</th>
<th>No. of Tubes</th>
<th>Date Control Console was Installed</th>
<th>Type of Install</th>
<th>SELECT TYPE if applicable</th>
<th>GENERAL</th>
<th>DENTAL</th>
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<td></td>
<td></td>
<td>MOBILE</td>
<td>DIGITAL</td>
<td>HANDHELD (prior approval required)</td>
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</table>

8. **LIST Deleted Units**

- ☐ Taken by Service Company
- ☐ Salvaged
- ☐ Sent to Land Fill
- ☐ Donated
- ☐ Out of State
- ☐ Made Permanently Inoperable

9. **LIST Stored Units** – Effective July 1, 2006 **Stored X-ray Facilities** will be subject to the Annual Fee.

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

    Individual/Business ___________________________ Phone Number: (_____)_________ Fax Number (_____)_________

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

11. **Radiation Safety Officer (Required):**

    Name of Contact ___________________________ Phone Number: (_____)_________ Fax Number (_____)_________

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

12. **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 ___________
# M7.

**LIST MAMMOGRAPHY UNITS USE CONTROL CONSOLE INFORMATION**  
Registration fees are due upon issuance of registration and annually thereafter on July 1 in accordance with 15A NCAC 11.1102.

<table>
<thead>
<tr>
<th>Room Number</th>
<th>Manufacturer</th>
<th>Model Name</th>
<th>FDA #</th>
<th>Serial Number</th>
<th>Date of MFG</th>
<th>No. of Tubes</th>
<th>Date Control Console was Installed</th>
<th>ADDING UNIT</th>
<th>FILM SCREEN</th>
<th>DIGITAL DR</th>
<th>COMPUTED RAD - CR</th>
<th>MOBILE</th>
<th>TOMOSYNTHESIS</th>
<th>STEREOTACTIC</th>
<th>STEREOTACTIC MOBILE</th>
<th>ACCREDITED BY ACR</th>
<th>BIOSPY/LOC P</th>
<th>NP</th>
<th>SPECIMEN CABINET - P</th>
<th>EDUCATION P</th>
<th>NP</th>
<th>RESEARCH P</th>
<th>VET - NP</th>
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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: [ ]