RADIATION PROTECTION SECTION

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

APPLICATION FOR REGISTRATION OF RADIATION UNITS AND FACILITIES
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: ☐ 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): 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: _____

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

Check appropriate boxes for each x-ray unit

Mammography Units use Addendum Page.

Room Number	Manufacturer	Model Number/Name	Control Serial Number	No. of Tubes	Date Control Console was Installed	Type of Install			SELECT TYPE if applicable			GENERAL						DENTAL			
						First Install This Location	Replacement	Relocation of Existing Unit	MOBILE	DIGITAL	HAND-HELD (prior approval required)	RADIOGRAPHIC	FLUOROSCOPIC	CT SCANNER	C-ARM	BONE DENSITY	THERAPY	INTRAORAL	PANORAMIC	CEPHALOMETRIC	CONE BEAM
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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

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