

REGISTRATION OF RADIATION MACHINE FACILITIES

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Facility:	Facility Supervisor:
Address:	
Telephone:	E-mail:

Type of Practice:

<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Podiatric	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Hospital	<input type="checkbox"/> Mammographic
<input type="checkbox"/> Veterinary	<input type="checkbox"/> Industrial	<input type="checkbox"/> Academic	<input type="checkbox"/> State owned / operated	<input type="checkbox"/> Other	<input style="width: 100px;" type="text"/>

Radiation Safety Officer (RSO):

Address:

Telephone: **E-mail:**

Type of Radiation Machine:

<input type="checkbox"/> Radiographic	<input type="checkbox"/> Dental	<input type="checkbox"/> Therapy	<input type="checkbox"/> Fluoroscopic	<input type="checkbox"/> Panographic	<input type="checkbox"/> Cephalometric	<input type="checkbox"/> Mammographic
<input type="checkbox"/> Computerized Tomography	<input type="checkbox"/> Bone Densitometry	<input type="checkbox"/> Combination Fluoro – Radiographic	<input type="checkbox"/> Intensifier			
<input type="checkbox"/> Combination PET – CT	<input type="checkbox"/> Industrial	<input type="checkbox"/> Other	<input style="width: 100px;" type="text"/>	Room #	<input style="width: 50px;" type="text"/>	

Radiation Machine: Stationary Portable Mobile

Manufacturer	<input style="width: 150px;" type="text"/>	Model number	<input style="width: 150px;" type="text"/>
Console serial:	<input style="width: 150px;" type="text"/>	Tube serial:	<input style="width: 150px;" type="text"/>
Rating - Max. kVp:	<input style="width: 50px;" type="text"/>	Max. mA:	<input style="width: 50px;" type="text"/>
Supplier:	<input style="width: 150px;" type="text"/>	Installer:	<input style="width: 150px;" type="text"/>
Service agent:	<input style="width: 150px;" type="text"/>	Geog. Location:	<input style="width: 150px;" type="text"/>

Inspection: Never Inspected Date of last inspection:

Inspected by whom:

Administrator/Machine Owner:

Address:

Telephone: **E-mail:**

CHECK #:

AMOUNT:

OFFICE USE ONLY:

FACILITY ID #:	<input style="width: 100px;" type="text"/>
REGISTRATION #:	<input style="width: 100px;" type="text"/>
EXPIRATION DATE:	<input style="width: 100px;" type="text"/>
TOTAL # OF TUBES:	<input style="width: 100px;" type="text"/>