

RADIOLOGICAL HEALTH PROGRAM
RADIATION MACHINE FACILITY REGISTRATION INSTRUCTIONS

PLEASE READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE ATTACHED FORM

01. Facility Name, Telephone, Fax, E-mail Address Print the name of the legal or business entity which owns or controls the use of the x-ray machines, including telephone number. If there is a fax number and e-mail address, enter in the spaces provided.
02. Street Address Print the street address or location where the above facility is physically located.
03. Mailing Address Print the mailing address if that address is different from the street address.
04. Contact Person Indicate the person that the State should contact regarding registration, inspection, and compliance issues, along with title where appropriate.
05. Profession Choose profession from menu. If none of the categories applies, choose **other**.
06. Federal Tax ID Insert the Federal Tax Identification number or Social Security number and indicate which it is.
- Privacy Act Notice:** This Notice is provided pursuant to the Federal Privacy Act of 1974, 5 U.S.C. § 552a. Disclosure of your Social Security or Federal Tax Identification on this form is mandatory pursuant to the provisions of § 1-203 (2003) of Environment Article, Annotated Code of Maryland, which requires MDE to verify that an applicant for a permit or license has paid all undisputed taxes and unemployment insurance. Social Security and Federal Tax Identification Nos. will not be used for any purposes other than those described in this Notice.
07. County Insert the county where the x-ray machine(s) is/are physically located.
08. Machine Group/Number Leave this area BLANK - For agency or private inspector use.
09. Component Use See attached menu. Use only one line for each machine or processor.
10. Control or Processor Select the number of the manufacturer of the source of radiation or processor from the attached menu. If the manufacturer is **other**, enter the number of **other** and specify manufacturer.
11. Tube Serial Number
Processor Model Supply a tube or control serial number to identify the equipment – not all processors have serial numbers, so specify the model of the processor.
12. Room Identification
Location Enter the name of the room or the specific location where the component can be found. These names are those commonly used...Blue Suite, Room 202, etc.
13. Manufacturer's Preventative
Maintenance Schedule Provide the preventative maintenance schedule, in months, of each radiation machine to ensure compliance with the regulations.

Return All Three Copies A validated copy will be returned bearing an assigned registration number.



RADIOLOGICAL HEALTH PROGRAM
MENU

<p>05. CODE PROFESSION</p> <p>10 Hospital 11 Chiropractor 12 Dentist 13 Physician 14 Podiatrist 15 Radiologist 16 Industrial/Field Radiography 17 Veterinarian 18 State/Local Government 19 Education/Research 20 Portable/Mobile X-ray 21 Other</p> <p>09. COMPONENT USE</p> <p>CODE DENTAL</p> <p>CBCT Cone Beam Computed Tomography CD Cephalometric CP Cephalometric/Intra-oral Comb. CX Pan/Ceph Combination HH Hand-held ID Intra-oral XD Panorex TD TMJ Work OD Other Dental</p> <p>CODE VETERINARY</p> <p>VP Veterinary Portable VS Veterinary Stationary</p> <p>CODE MEDICAL</p> <p>AD Angiography/Digital AN Angiography BD Bone Densitometry CA CAT Scanner CE Ceiling Tube (Leg Studies) CH Chest, Dedicated CI Chiropractic DI Diathermy GP General Purpose HN Head and Neck MA Mammography MI Magnetic Imaging OT Other Medical PD Podiatry PH Portable Hand Carried PM Portable Mobile SR Stereotactic TO Tomography UR Urology US Ultrasound</p>	<p>CODE DARKROOM</p> <p>AP Automatic Processor DD Complete Digital Imaging IP Insta-fix only processing MP Manual Processing NP No processing on-site</p> <p>CODE MEDICAL THERAPY</p> <p>AT Accelerator CT Contact Therapy DT Deep X-ray ST Superficial</p> <p>CODE INDUS/EDUC/RESEARCH</p> <p>IA Accelerator IC Cabinet Radiography IE Electron Microscope IF Field Radiography IG Gauge IN Diffraction IO Other Indus./Educ./Research IR Room Radiography IS Spectrographic</p> <p>CODE MEDICAL FLUOROSCOPE</p> <p>AF Above Table Tube BF Below Table Tube CF C-Arm MF Mobile Fluoroscope UF Upright Fluoroscope OF Other Medical Fluoroscope</p> <p>10. CODE MANUFACTURER</p> <p>00 Imagie Works 01 AS and E 02 Accuray 06 Accudex 07 Acoma 03 Agfa 08 Air Techniques 14 All Pro 04 Andrex 05 Asoma 10 Astrophysics 12 Autoclear 16 Aztech 09 Belmont 11 Bennett X-ray 13 Bowie 18 Castle 15 Continental X-ray Corp. 17 Control Screening 19 Coromex 26 de Gotzen 29 Del Medical</p>	<p>10. (continued)</p> <p>22 Dentx 30 Dynavision 31 E.G. & G. 25 Elekta 20 Faxitron 21 Fischer Imaging Group 34 Fuji 23 Gendex 24 General Electric 35 Glenbrook 37 Global Marine 39 Golden 40 HCMI 41 Heimann 46 Heuft Systems Technik 27 Hewlett-Packard 28 Hitachi 38 Hologic 48 Hope 43 Instrumentarium 55 JEOL 32 J. Morita 33 Kodak 44 Konica 56 LG 47 Lorad 36 Lumix 49 Lunar 50 Midwest/Sybron 57 Min X-ray 61 Niton 42 OEC Diansonics 66 PANalytical 59 Panoramic Corp. 45 Phillips 60 Planmeca 70 Progeny 72 Protec 74 Rapiscan 51 Raytheon 73 Rigaku 52 Ritter 53 S.S. White 54 Sanko 78 Sedecal 79 Seiko 58 Siemens 80 Sirona 64 Soredex 81 Spectro 68 Summit 62 Toshiba 63 Transworld 71 Trophy 65 Universal 67 Varian 82 Vet Ray, Inc. 69 Weber 83 XMA 84 X-Cel 76 Yoshida 77 Other</p>
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1 Name of Facility _____ Telephone No. _____

Fax No.: _____ E-mail Address: _____

2 Street Address (machine location) _____ Suite _____ City _____ State _____ Zip Code _____

3 Mailing Address (if different) _____ Suite _____ City _____ State _____ Zip Code _____

4 Contact Person: _____ Title: _____ Contact Ph.#1: _____ Contact Ph.#2: _____

5 Profession (from menu): _____ 6 (check as appropriate and enter number)
 Fed Tax ID#: _____
 SS#: _____ 7 County: _____

8 Machine Group: _____ Machine Number Suffix		9 (menu) Component Use	10 (menu) Control or Processor Manufacturer	11 Tube Serial Number Processor Model	12 Room Location	13 PM Schedule (months)

I hereby certify that the information above is true and complete to the best of my knowledge.

Signature _____ Registrant's Name (print) _____ Date _____

Document and Date appropriate change to facility: REGISTRATION DOES NOT IMPLY APPROVAL OR DISAPPROVAL

New Facility Renewal Relocation Replacement of tube Additional tube Removal of tube

Date of appropriate change: ____/____/____

For Official Use Only

Reg. No.: _____ - _____

Initial of Approval: _____

Date ____/____/____
 M M D D Y Y

Inspector's #: _____

Date of Approval: _____

For Office Use Only Date Received



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Fax No.: _____ E-mail Address: _____

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