MARYLAND DEPARTMENT OF THE ENVIRONMENT
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MDE RX 21

RADIOLOGICAL HEALTH PROGRAM

APPLICATION FOR PLAN REVIEW

Regulation COMAR 26.12.01.01 B.4(a) requires that:

"At least 30 days prior to the installation or relocation of a radiation machine intended for use for diagnostic or therapeutic purposes, any person owning or operating a radiation machine facility shall submit to the Department the floor plan and equipment arrangement of all new installations, or modifications of existing installations."

In order to meet this regulation this form must be filled out.

A. GENERAL INFORMATION:

PRESENT MAILING ADDRESS

_____
Name

_____
Address

_____
City, State Zip Code

_____
Telephone Number

PLAN PREPARED BY

_____
Name Prepared Date

_____
Address

_____
City, State Zip Code

_____
Telephone Number

PROPOSED/EXISTING FACILITY ADDRESS

_____
Name

_____
Address

_____
City, State Zip Code

_____
County

FOR EXISTING FACILITY, GIVE FACILITY REGISTRATION NUMBER:

☐☐ — ☐☐☐☐

Max. Rated Tube Potential _____kVp

Max. Rated Continuous mA _____

B. INSTALLATION PLAN

A drawing must be attached that includes the following information:

1. Tube Location
2. Cassette Location(s)
3. Primary Beam Directions
4. Control Location
5. Exposure Switch Location
6. Scale of drawing (inches/foot)
7. Patient Viewing Device Location
8. Use (Occupancy) of Space Behind Walls, Ceilings, and Floor
9. Room Identification

C. SHIELDING DATA TABLE for ROOM IDENTIFICATION: _____

Shielding	Chest Board	Control Booth	Doors	A	B	C	D	E	Floor	Ceiling
Lead, mm										
Concrete, inches										
Gyp. wallboard, inches										
Concrete block, inches										
Cinder block, inches										
Brick, inches										
Wood, inches										
Glass, inches										
Steel, inches										
Other ( )inches										

Unless provided with different information,* the Agency will assume the following workloads (mA-min/wk) for calculation:

1000 mA-min/wk for medical (GP) units
2000 mA-min/wk for fluoroscopic units
2000 mA-min/wk for special procedures
60 mA-min/wk for chiropractic units
20 mA-min/wk for podiatry units
_____mA-min/wk *must be provided for therapy/other units

Check type of unit:

Radiographic: wall _____ table: _____ Chiropractic: _____ Podiatry _____

Fluoroscopic: _____ Special Procedures: _____ Computed Tomography: _____

I certify that the facility will be constructed in accordance with the design specifications shown on this form.

_____ _____

Signature of facility representative Name of facility representative (print)

_____

Date