



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

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 | 60 mA-min/wk for chiropractic units |
| 2000 mA-min/wk for fluoroscopic units | 20 mA-min/wk for podiatry units |
| 2000 mA-min/wk for special procedures | _____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

