

RADIOLOGICAL HEALTH PROGRAM RADIATION MACHINE FACILITY REGISTRATION
PLEASE READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE ATTACHED FORM

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| 1. Facility Name, Telephone, Fax, MANDATORY E-mail | Print name of the legal entity which owns or controls the x-ray machines, including telephone number, fax number, and e-mail address. |
| 2. Street Address | Print street address/location where machine(s) is/are physically located. |
| 3. Mailing Address | Print mailing address if different from street address. |
| 3A. Billing Address | Print billing address if different. |
| 4. Contact Person | Indicate person the Department should contact regarding registration, inspection, and compliance issues. Include person's title. |
| 5. Profession | Choose Profession from menu. |
| 6. Federal Tax ID | Insert Federal Tax Identification number or Social Security number. |
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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, <u>Annotated Code of Maryland</u> , 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. | |
| 7. County | Insert the county where the x-ray machine(s) is/are physically located. |
| 8. Machine Group/Number/Suffix | Print the machine group and number (MDE issued red sticker) if known. Suffix is A if the tube has one tube head. |
| 9. Component Use | See attached menu. Use only one line for each machine or processor. |
| 10. Manufacturer of Controllor | 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. Machine Model | Specify the model of the machine. |
| 12. Tubehead Serial Number | Supply the serial number of the machine tubehead. |
| 13. Room Location | Enter the name of the room or the specific location where the component can be found. |
| 14. Manufacturer's Preventive Maintenance Schedule | Provide the preventative maintenance schedule, in months, of each radiation machine to ensure compliance with the regulations. |
| 15. Date of Last PM Service | Provide the date the identified machine last had preventive maintenance performed by an active registered service provider. Ensure that all PM reports are submitted to the Department. |

Return the Form to the Radiological Health Program



MARYLAND DEPARTMENT OF THE ENVIRONMENT
1800 Washington Boulevard, Suite 750 • Baltimore Maryland 21230
1-800-633-6101 ext. 3193 • www.mde.maryland.gov • mdextray.submission@maryland.gov

RADIOLOGICAL HEALTH PROGRAM RADIATION MACHINE FACILITY REGISTRATION MENU

05. CODE PROFESSION 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 08. MACHINE GROUP 1 Irradiation of Materials 2 Human Medical Therapy 3 Hospital 4 Medical Office 5 Industrial, Research, and Academic 6 Dental 7 Veterinary 8 Mammography 9 Veterinary Dental 09. COMPONENT USE CODE DENTAL 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 CODE VETERINARY VP Veterinary Portable VS Veterinary Stationary VD Veterinary Dental CODE MEDICAL 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	CODE DARKROOM AP Automatic Processor DD Complete Digital Imaging IP Insta-fix only processing MP Manual Processing CODE MEDICAL THERAPY AT Accelerator CT Contact Therapy DT Deep X-ray EB Electronic Brachytherapy OBI On-Board Imaging ST Superficial CODE INDUS/EDUC/RESEARCH 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 CODE MEDICAL FLUOROSCOPE AF Above Table Tube BF Below Table Tube CF C-Arm MF Mobile Fluoroscope UF Upright Fluoroscope OF Other Medical Fluoroscope 10. CODE MANUFACTURER 00 Image 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 22 Dentx 30 Dynavision	10. (continued) 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 HCM 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
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RADIOLOGICAL HEALTH PROGRAM RADIATION MACHINE FACILITY REGISTRATION

1 Name of Facility _____ Telephone No. _____

Fax No.: _____ E-mail Address (MANDATORY): _____

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

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

3A Billing 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 _____ or ☐ Soc Sec No _____		7 County:

8 (menu) Machine Group: _____ Machine Number _____ Suffix _____	9 (menu) Component Use	10 (menu) Manufacturer	11 Machine Model	12 Tube Head Serial Number	13 Room Location	14 PM Schedule (months)	15 Date of Last PM

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

Fill in applicable box below:

☐ New Facility ☐ Renewal ☐ Relocation ☐ Replacement of tube ☐ Additional tube ☐ Removal of tube ☐ Change of Ownership

Enter Facility Registration No.: _____ - _____ (Date _____)

OFFICIAL USE ONLY

Reg. No.: _____ - _____

Expiration Date _____ / _____ / _____
M M D D Y Y

MDE/ARA/PERMIT#007 (MDE
RX1) Revised 7/18/19
TTY Users 1-800-201-7165

Initial of Approval: _____ Fee Amt. Rec'd: \$ _____

Inspector's #: _____ Date Fee Rec'd: _____

Date of Approval: _____ RX-1 Rec'd: _____

