



**APPLICATION FOR REGISTRATION OF X-RAY UNITS AND FACILITIES
HEALING ARTS**

Initial Registration New Satellite Office Amended Registration We've moved Reg. No _____

1. PHYSICAL ADDRESS: Physical location of facility & x-ray unit(s) Please list your equipment on the 2nd sheet & sign

Facility Name: _____ Phone Number: (____) _____
Facility Contact: _____ Fax Number: (____) _____
Physical Address: _____ E-mail: _____
City: _____ County: _____ State: _____ Zip Code + 4 _____

2. MAILING ADDRESS: (If different than item 1):

County Code of Facility _____

Mailing Contact: _____
Mailing Address: _____ E-mail: _____
City: _____ State: _____ Zip Code + 4 _____
Phone Number: (____) _____ Fax Number: (____) _____

3. ACCOUNTING SPECIALIST/BILLING OFFICE:

****MUST BE COMPLETED****

Billing Contact Person: _____ Phone Number: (____) _____
Billing Address: _____ Fax Number: (____) _____
City _____ E-Mail: _____
State: _____ Zip Code + 4 _____

4. OWNER, PARTNER OR CORPORATE OFFICER: Persons Financially Responsible for Facility and/or X-ray unit(s)

****MUST BE COMPLETED****

CORPORATE NAME: _____ Phone Number: (____) _____
Address: _____ City: _____ State: _____ Zip Code _____

OWNERSHIP: SOLE PROPRIETOR LLC LLP INC NON PROFIT INC PA PC

5. TYPE OF FACILITY:

Chiropractic Dental Educational Government Health Dept Imaging Center
 Hospital Clinic Physician Podiatry Mobile Service Veterinarian

6. INSTALLER INFORMATION or PREVIOUSLY INSTALLED FOR: _____

Old Registration Number _____

Business Name _____
Phone Number: (____) _____ Address: _____
City: _____ State: _____ Zip Code _____

7. The provisions of 15A NCAC 11 .0203, requires registration of x-ray facilities and each radiation machine within 30 days following initial operation of the facility and each radiation machine. Registration fees are due upon date of issuance of registration and annually thereafter on July 1 in accordance with 15A NCAC 11.1102.

Check appropriate box for each x-ray unit

LIST ALL X-RAY UNITS USE CONTROL CONSOLE INFORMATION

Room Number	Manufacturer	Model Number/Name	Control Serial Number	No. of Tubes	Date Control Console was Installed	ADDING Unit	MOBILE	DIGITAL	RADIOGRAPHIC	FLUOROSCOPIC	CT SCANNER	C-ARM	INTRAOURAL	PANOREX	CEPHALOMETRIC	CONE BEAM DENTAL	BONE DENSITY	OTHER (Specify)	Mammo use Addedum page
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. LIST Deleted Units Taken by Service Company Salvaged Sent to Land Fill Donated Out of State Made Permanently Inoperable

9. LIST Units NOT in Use – Not in Use units are subject to the Annual Fees.

10. Please list recipient of sold, deleted or donated x-ray units:

Individual/Business _____ Phone Number: (____) _____ Fax Number (____) _____

City: _____ State: _____ Zip Code + 4 _____ Email _____

THE RADIATION SAFETY OFFICER OR PERSON RESPONSIBLE FOR RADIATION AT YOUR FACILITY MUST BE IDENTIFIED IN YOUR RADIATION PROTECTION PROGRAM.

11. THE LEGAL OWNER OR RADIATION PROTECTION REPRESENTATIVE OR AUTHORIZED DESIGNEE MUST SIGN AND CERTIFY ALL INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE:

Date: _____ Signature: _____ Print Name: _____ Title: _____

____ Inspector Initials _____ Date Accept Accept with Changes Reject

