Application for Registration and Instructions for

X-Ray Equipment Storage Facility

RI General Laws Chapter 23-1.3

Registrant Name: _____

Registration Number: STO

Reason for application (Please check all that apply):

1. ☐ Initial Registration
2. ☐ Change of address: What is your current registration number:_____
3. ☐ Change of ownership: What is your current registration number:_____
4. ☐ Registrant Name Change: _____

For Agency Use Only	Category: STO Registration No.: _____ Conditions: Storage Only
	Reviewed By: _____ Date: _____ Amount Paid: N/A
	Number of Active X-Ray Tubes: N/A Number of X-Ray Tubes in Storage: _____

State of Rhode Island
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your registration will not be issued. Please use a ball point pen.

- There is no fee for an X-Ray Equipment Storage Facility registration application. However, before a diagnostic X-ray system can return to active use the facility must complete an application to become an active Diagnostic X-Ray Equipment Facility. X-Ray systems must be installed by a Provider of X-Ray Services registered with the State of Rhode Island. This may also require the completion of a Shielding Plan and Evaluation to be conducted by a Radiation Physics Service provider registered with the State of Rhode Island.

- Sign the completed application and return to:

  Radiation Control Program
  Center for Health Facilities Regulation
  Rhode Island Department of Health
  3 Capitol Hill, Room 305
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the Radiation Control Program at (401) 222-2566.

- Registration application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Processing: For expedited processing of your registration, a valid email address must be provided wherever requested.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Facility Supervisor Information: Please provide the name of the Facility Supervisor for this facility.	Name: _____ Registration Number: (DEN,MD, DO)_____ Email Address: _____ Phone Number: _____
Individual Responsible for Radiation Protection:	Name: _____ Phone Number: _____ Title: _____ Email Address: _____

Facility Name: Please provide the name of the facility (as known to the public).	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Email Address: _____ Phone Number: _____

Facility Mailing Information: Please provide the mailing information for all communication regarding this registration. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. (**Published on HEALTH website**)	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Partner ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership
Ownership Information: (Registrant) Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ (Registration Holder) DBA: _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone: Fax: _____ Email Address: _____

Consulting Radiation Physics Service (if applicable):	Name: _____ RI Registration #: RPS_____
Storage X-Ray Tube Information: Provide the requested information for each diagnostic X-ray system at the facility	

Manufacturer	Model	# of Tubes	Location (within facility)

X-Ray Storage Stipulations:	**Before a diagnostic X-ray system can return to active use the facility must complete an application to become an active Diagnostic X-Ray Equipment Facility. X-Ray systems must be installed by a Provider of X-Ray Services registered with the State of Rhode Island. This may also require the completion of a Shielding Plan and Evaluation to be conducted by a Radiation Physics Service provider registered with the State of Rhode Island.**

Acknowledgements

I am aware of Chapter 23-1.3 of the General Laws of Rhode Island, 1978, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Agency shall, in conformity with the authority continued under Chapter 23-1.3 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any registration, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below SSN/FEIN for this registration: SSN/F.E.I.N. Number: _____
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed by the Facility Supervisor** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of this Registration in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** _____ _____ **Signature of Authorized Person** **Date of Signature (MM/DD/YY)** _____ **Printed Name of Authorized Person** _____ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.**