

Ownership Type: Please check ONE	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Governmental Entity	<input type="checkbox"/> Partner
	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Partnership	

Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____
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ANALYTICAL X-RAY SYSTEMS INFORMATION: Provide the requested information for each analytical X-ray system owned or possessed by the facility.

Unit #	Manufacturer	Model	# of Tubes	Installer	Location

[Continue on plain 8½" by 11" paper if necessary.]

RADIATION SAFETY PROGRAM:
Attach a description of the facility's proposed method of fulfilling the requirements of Section E.3.4 ["Personnel Requirements"] Rules and Regulations for the Control of Radiation [R23-1.3-RAD].

IDENTIFY THE DOSIMETRY SERVICE PROVIDER TO BE USED AT THE FACILITY:

FEIN Number: (Federal Employer Identification Number) Note: If you are a sole proprietor this number may be your Social Security Number.	Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, 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 FEIN/SSN for this license: F.E.I.N./SSN Number: _____
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CERTIFICATION [Must be completed by applicant]:
The applicant and any official executing this certification on behalf of the applicant, certify that this application is prepared in conformity with the Rhode Island Rules and Regulations for the Control of Radiation [R23-1.3-RAD], and that all information contained herein is correct to the best of their knowledge and belief.

_____	_____
(Signature)	(Type or Print Name of Certifying Official)
_____	_____
Date	Title: