



**RHODE ISLAND RADIATION CONTROL AGENCY
APPLICATION FOR REGISTRATION
OF A CABINET X-RAY FACILITY**

****FOR AGENCY USE ONLY****

Category Lic. No. Conditions _____

Reviewed By _____ / / _____ \$ _____
Date Amount Paid

INSTRUCTIONS: Subpart B.3 and Section E.2.1 (b) of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD] contains detailed instructions for completing this application. Send the entire completed application to: **RI Department of Health, Office of Facilities Regulation, Radiation Control Program, 3 Capitol Hill - Room 305, Providence, RI 02908-5097.** You should keep a copy of your completed application and attachments, as they will be incorporated into your registration by reference. Checks should be made payable to RI General Treasurer.

THIS IS AN APPLICATION FOR [*Check Appropriate Item*] NEW REGISTRATION
 AMENDMENT TO REGISTRATION # _____ CATEGORY CHANGE TO REGISTRATION _____

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: () _____
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (Not published on HEALTH website).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, ZipCode _____ 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, ZipCode _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Individual Responsible for Radiation Protection:	Name: _____ Phone Number: _____ Title: _____
Consulting Radiation Protection Service [if applicable]:	Name: _____ RI Registration#: RPS _____

Ownership Type:
Please check ONE

Corporation
 Limited Liability Company
 Governmental Entity
 Partner
 Sole Proprietorship
 Partnership
 Limited Partnership

Ownership Information:
Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

Name: _____

DBA: _____

CABINET X-RAY SYSTEMS INFORMATION: Provide the requested information for each cabinet X-ray system owned or possessed by the facility.

Unit #	Manufacturer	Model	Installer	Location

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

OPERATING PERSONNEL:
Identify on an 8½ x 11 sheet of paper, all individuals who will be authorized to operate the cabinet X-ray system(s).

DOSIMETRY SERVICE: Yes No

Name _____

Address (Street) _____ City _____ State _____ ZipCode _____

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: _____

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: