

RHODE ISLAND RADIATION CONTROL AGENCY

APPLICATION FOR REGISTRATION OF A DIAGNOSTIC X-RAY EQUIPMENT FACILITY

FOR AGENCY USE ONLY

Category Reg No. Tubes: Active: _____ Storage: _____

 Reviewed By _____ Date _____ \$ _____
 Amount Paid _____

INSTRUCTIONS: Subpart B.3 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, Radiological Health Program, 3 Capitol Hill - Room 306, 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 Treasurer-State of Rhode Island.

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, 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: _____

Facility Supervisor Information:
 Name: _____ Phone Number: () _____
 RI Medical/Dental License Number: _____ Specialty: _____
 Medical/Dental Board Certification(s): _____ Date(s): _____

Individual Responsible for Radiation Protection:
 Name: _____ Phone Number: () _____
 Title: _____

Consulting Radiation Protection Service [If applicable]:	Name: _____ RI Registration#: <u>RPS-</u> _____
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Ownership Type: Please check ONE	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership
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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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THE CUSTOMARY AND USUAL RADIOGRAPHIC PROCEDURES PERFORMED AT THE FACILITY ARE:
[Check ALL Applicable Items]

<input type="checkbox"/> 0. None: equipment stored	<input type="checkbox"/> 6. Chiropractic	<input type="checkbox"/> 11. Contrast Media Studies
<input type="checkbox"/> 1. Dental Intraoral	<input type="checkbox"/> 7. Veterinary	<input type="checkbox"/> 12. CT
<input type="checkbox"/> 2. Dental Extraoral	<input type="checkbox"/> 8. General Radiographic	<input type="checkbox"/> 13. Bone Densitometry
<input type="checkbox"/> 3. Cephalometric	<input type="checkbox"/> 9. Fluoroscopic	<input type="checkbox"/> 14. Podiatric
<input type="checkbox"/> 4. Chest and/or Extremities	<input type="checkbox"/> 10. Mammographic	
<input type="checkbox"/> 5. Specific Radiography (Specify) _____		

DIAGNOSTIC X-RAY SYSTEMS INFORMATION: Provide the requested information for each diagnostic X-ray system at the facility.

Unit #*	Manufacturer	Model	# of Tubes	Location	Use**

*Unit # used to identify X-ray equipment should also be used to identify that same X-ray equipment in the shielding evaluation.
 **Use: Indicate the use of the equipment by inserting the number of the radiographic procedure listed. [Continue on plain 8½" by 11" paper if necessary.]

SHIELDING EVALUATION:
 The type and scope of information to be provided is described in Appendix A to part B of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD].

FEIN Number: (Federal Employer Identification Number) Note: If you are a sole proprietor this number may be your Social Security Number.	<p>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.</p> <p>Please provide below FEIN/SSN for this license: F.E.I.N./SSN Number: _____</p>
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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

FACILITY SUPERVISOR: _____
 [If different from Certifying Official]: (Signature) _____ (Date) _____



Rhode Island Department of Health
3 Capitol Hill, Providence RI, 02908-5097
MANDATORY ADDENDUM TO LICENSE APPLICATION
Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # _____)
- I am in state receivership. (Case # _____)
- I have been discharged from Bankruptcy.
(Case # _____)

Type of Professional/Business License for which you are applying

Full Name (Please Print or Type)

Social Security Number (or FEIN for Business)

Signature

Phone Number (including area code if not 401)

Date

Name of Business (If Applicable)

This form must be completed, signed and attached to your license application for processing.