

**RHODE ISLAND RADIATION CONTROL AGENCY**  
**APPLICATION FOR REGISTRATION OF**  
**INDIVIDUALS PROVIDING RADIATION PHYSICS SERVICES**

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

Category  R  P  S Reg No.

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_ \$ \_\_\_\_\_  
**Amount Paid**

**INSTRUCTIONS:** Subpart B.4 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 #: **RPS-** \_\_\_\_\_

**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: \_\_\_\_\_

**Individual Responsible for Radiation Protection:**

Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Title: \_\_\_\_\_

**Ownership Type:**  
Please check ONE

Corporation  Limited Liability Company  Governmental Entity

Sole Proprietorship  Partnership  Limited Partnership





**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 # \_\_\_\_\_)

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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.*