

**RHODE ISLAND RADIATION CONTROL AGENCY**

**APPLICATION FOR REGISTRATION OF A THERAPEUTIC RADIATION MACHINE FACILITY**

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

Category    Reg No.     Tubes: Active: \_\_\_\_\_ Storage: \_\_\_\_\_  
 \$ \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_ Amount Paid \_\_\_\_\_

**INSTRUCTIONS:** Subparts B.3 and H.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: \_\_\_\_\_

<p><b>Facility Name:</b> Please provide the name of the facility (as known to the public) for which you are applying for this license.</p>	<p>Name: _____</p>
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<p><b>Facility Contact Person:</b> Please provide the name and telephone number of a person we can contact concerning this facility.</p>	<p>Name: _____ Phone Number: ( ) _____</p>
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<p><b>Facility Mailing Information:</b> Please provide the mailing information for all communication regarding this license. <b>(Not published on HEALTH website).</b></p>	<p>Address Line 1: _____                  Address Line 2: _____                  Address Line 3: _____                  Address City, State, Zip Code: _____                  Address Country: _____                  Phone: ( ) _____ Fax: ( ) _____ Email Address: _____</p>
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<p><b>Facility Location Information:</b> Please provide the location information for this facility. <b>(Published on HEALTH website).</b></p>	<p>Address Line 1: _____                  Address Line 2: _____                  Address Line 3: _____                  Address City, State, Zip Code: _____                  Address Country: _____                  Phone: ( ) _____ Fax: ( ) _____ Email Address: _____</p>
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<p><b>Facility Supervisor Information:</b></p>	<p>Name: _____ Phone Number: ( ) _____                  RI Medical/License Number: _____ Specialty: _____                  Medical/Board Certification(s): _____ Date(s): _____</p>
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<p><b>Individual Responsible for Radiation Protection:</b></p>	<p>Name: _____ Phone Number: ( ) _____                  Title: _____</p>
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<b>Radiotherapy Physicist:</b> RI Registration Number: <b>RPS-</b>	Name: _____ Address: _____	Phone Number: _____
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<b>Ownership Type:</b> 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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<b>Ownership Information:</b> Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____  DBA _____
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**INTENDED USE OF THERAPEUTIC RADIATION MACHINE(S):** [*Check ALL Applicable Items*]

5-50 kV System(s) [H.6]       Photon Therapy System(s) (500 kV & above) [H.7]  
 >50 and <500 kV System(s) [H.6]       Electron Therapy System(s) (500 keV & above) [H.7]

**THERAPEUTIC RADIATION MACHINE INFORMATION:** Provide the requested information for each therapeutic radiation machine owned or possessed by the facility.

Unit #*	Manufacturer	Model	Energy	Type	Location

\*Therapeutic radiation machines also require submission of a shielding evaluation and documentation of compliance with Subpart H.9 of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD] for each location/unit.  
 [Continue on plain 8½" by 11" paper if necessary.]

**OPERATING PERSONNEL:**  
 Identify all individuals who will be authorized to operate the therapeutic radiation machine(s). Provide documentation of compliance with Section H.3.5 of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD] for each individual.

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

\_\_\_\_\_

**DOSIMETRY EQUIPMENT:** Identify the dosimetry equipment that will be used to demonstrate compliance with Section H.4.3 of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD].

<b>FEIN Number:</b> (Federal Employer Identification Number)  Note: If you are a sole proprietor this number may be your Social Security Number.	<p><b>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.</b></p> 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

**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.*