



**RHODE ISLAND RADIATION CONTROL AGENCY  
APPLICATION FOR REGISTRATION  
OF X-RAY EQUIPMENT SERVICES**

**Category**    **Lic. No.**      **\*\*FOR AGENCY USE ONLY\*\***  
**Conditions** \_\_\_\_\_  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \$ \_\_\_\_\_  
**Reviewed By** \_\_\_\_\_ **Date** \_\_\_\_\_ **Amount Paid** \_\_\_\_\_

INSTRUCTIONS: Subpart 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, 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 \_\_\_\_\_

<b>Facility Name:</b> Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name: _____
<b>Facility Contact Person:</b> Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: (____) _____
<b>Facility Mailing Information:</b> 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: _____
<b>Facility Location Information:</b> 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: _____
<b>Individual Responsible for Radiation Protection:</b>	Name: _____ Phone Number: _____ Title: _____

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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**X-RAY EQUIPMENT SERVICES REQUESTED: [Check ALL Applicable Items]**

Calibration of radiation measurement equipment

Installation and/or servicing of x-ray equipment

Personnel dosimetry services

Other specialized radiation physics services and/or surveys [Specify]

Date Services Established (MM/DD/YYYY): \_\_\_\_\_

Date Services Established in Rhode Island (MM/DD/YYYY): \_\_\_\_\_

**SUBMIT THE FOLLOWING ITEMS ON 8 1/2 " x 11" PAPER. THE TYPE AND SCOPE OF INFORMATION TO BE PROVIDED IS DESCRIBED IN APPENDIX B TO PART B OF THE RULES AND REGULATIONS FOR THE CONTROL OF RADIATION [R23-1.3-RAD]**

Professional Certifications Held:	Please identify and provide current copies of all relevant professional certifications/licenses currently held by the applicant.
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Formal Training of Applicant:	Provide documentation of all formal academic training, short courses and continuing education, which qualify the applicant to perform the services being requested.
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Experience of Applicant:	Provide documentation of on-the-job experience which qualify the applicant to perform the services being requested.
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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) \_\_\_\_\_  
Date \_\_\_\_\_

\_\_\_\_\_  
(Type or Print Name of Certifying Official) \_\_\_\_\_  
Title: \_\_\_\_\_

**FACILITY SUPERVISOR:** \_\_\_\_\_  
[If different from Certifying Official]: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)