



Radiation Control Program

Application for General License Radioactive Material



NAME OF BUSINESS

BUSINESS STREET ADDRESS

CITY

STATE

ZIP CODE

BUSINESS LICENSE #

BUSINESS TELEPHONE NUMBER

FAX NUMBER

E-MAIL ADDRESS

NAME OF MANUFACTURER OR INITIAL TRANSFEROR OF THE DEVICE(S)

DEVICE INFORMATION

DEVICE	MANUFACTURER	MODEL #	# REC'D	DATE REC'D	PHYSICAL LOCATION
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____

RADIOISOTOPE INFORMATION

DEVICE	RADIOISOTOPE	ACTIVITY	SERIAL #	TYPE OF DEVICE	INITIAL
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____

ADDRESS OF DEVICES¹

STREET ADDRESS

CITY

STATE

ZIP CODE

LEAK TESTING

How often will the devices be leak tested? ___ months ___ year(s)

Who will perform leak testing? _____

NAME OF DESIGNATED PERSON

CONTACT INFORMATION

NAME OF OWNER OR SENIOR MGR

TELEPHONE NUMBER

FAX NUMBER

E-MAIL

DESIGNATED RESPONSIBLE PERSON

TELEPHONE NUMBER

FAX NUMBER

E-MAIL

¹ if different from business address listed above

