

RADIATION CONTROL PROGRAM
X-ray Machine Registration



NAME OF FACILITY			
PREVIOUS REG NO.	TELEPHONE NO.	FAX NO.	
MAILING STREET ADDRESS		CITY	STATE ZIP CODE
ADDRESS WHERE MACHINE WILL BE USED (IF DIFFERENT)		CITY	STATE ZIP CODE
DEPARTMENT OR ROOM WHERE MACHINE WILL BE USED			
NAME OF PERSON RESPONSIBLE FOR RADIATION SAFETY		TITLE (e.g., RSO)	E-MAIL ADDRESS

IS THIS A LICENSED ACADEMIC INSTITUTION? YES NO

HUMAN MEDICAL X-RAY

- | | |
|---|--|
| <input type="checkbox"/> Stereotactic
<input type="checkbox"/> Radiographic - stationary
<input type="checkbox"/> Radiographic - mobile and portable
<input type="checkbox"/> Combination radiographic and fluoroscopic
<input type="checkbox"/> Podiatry | <input type="checkbox"/> C-arm - fixed
<input type="checkbox"/> Cabinet Biopsy Machine
<input type="checkbox"/> DEXA - bone density
<input type="checkbox"/> C-arm - mobile
<input type="checkbox"/> Other _____ |
|---|--|

CT - ALL COMPUTED TOMOGRAPHY (INCLUDING, BUT NOT LIMITED TO: WHOLE BODY, HEAD, FACE AND NECK)

CT

HUMAN DENTAL X-RAY

- | | |
|--|---|
| <input type="checkbox"/> Panoramic
<input type="checkbox"/> Cephalometric | <input type="checkbox"/> Handheld
<input type="checkbox"/> Intraoral
<input type="checkbox"/> Other _____ |
|--|---|

ACCELERATOR (MEDICAL / NON-MEDICAL)

Therapy Particle

NON-HUMAN / NON-MEDICAL

- | | |
|---|--|
| <input type="checkbox"/> Industrial security/baggage
<input type="checkbox"/> Industrial cabinet
<input type="checkbox"/> Industrial radiography (fixed port)
<input type="checkbox"/> Industrial flourescopic | <input type="checkbox"/> Analytical diffraction apparatus
<input type="checkbox"/> Electron Microscope
<input type="checkbox"/> Academic
<input type="checkbox"/> Other _____ |
|---|--|

VETERINARY MEDICAL

- | | |
|---|--|
| <input type="checkbox"/> Radiographic fixed
<input type="checkbox"/> Radiographic mobile
<input type="checkbox"/> Radiographic Portable | <input type="checkbox"/> Handheld
<input type="checkbox"/> Dental
<input type="checkbox"/> Fluoroscopic (fixed/mobile) |
|---|--|

MACHINE DESCRIPTION (One machine per application)

MANUFACTURER	MODEL NUMBER	CONTROL PANEL SERIAL NUMBER	NO. OF TUBES

SIGNATURE

NAME

TITLE

DATE

**To the best of my knowledge and belief, all information contained herein is true and correct.
 By signing the application, the applicant attests that all involved personnel have received training in safe injection practices.**

FOR OFFICE USE ONLY

REGISTRATION NUMBER	DATE PROCESSED	EXPIRATION DATE

Please send completed form and applicable fee to the following address:

Nevada State Health Division - Radiation Control Program
 727 Fairview Drive, Suite E - Carson City, NV 89701
 Tel: (775) 687-7550 - Fax: (775) 687-7552

Public Health Working for a Safer and Healthier Nevada