

REGISTRATION OF RADIATION MACHINE FACILITIES

FACILITY

NAME:

Street Address

Mailing Address

TELEPHONE:

RADIATION SAFETY OFFICER (RSO)

NAME:

ADDRESS:

TELEPHONE:

EMAIL

RADIATION MACHINE

MANUFACTURER: *leave blank*

MODEL NUMBER: *will be filled in*

CONSOLE SERIAL: *as part of online*

TUBE SERIAL: *registration*

RATING - MAX. kVp: *leave blank*

MAX. mA: *leave blank*

SUPPLIER: *leave blank*

INSTALLER: *leave blank*

SERVICE AGENT: *leave blank*

Stationary Portable Mobile

GEOG. LOCATION: *leave blank*

TYPE OF PRACTICE or FACILITY

Medical

Schools

Dental

Hospital

Podiatric

Mammographic

Chiropractic

Colleges

Industrial

State owned and

Veterinary

operated

OTHER

CONTACT PERSON

NAME:

EMAIL:

Facility email (if different):

RADIATION MACHINE

TYPE OF MACHINE:

Dental

Radiographic

Fluoroscopic

Intensifier

Cephalometric

Panographic

Therapy

Mammographic

Bone Densitometry

Computerized Tomography

Combination Fluoro - Radiographic

Combination PET - CT

Industrial

OTHER

ROOM #

SUPERVISING PHYSICIAN

NAME:

ADDRESS:

TELEPHONE:

EMAIL:

INSPECTION

DATE OF LAST INSPECTION: *leave blank*

INSPECTED BY WHOM: *leave blank*

NEVER INSPECTED *leave blank*

Email to : the x-ray staff who sent it to you or to radiation.dhhs@maine.gov

Mail to: Radiation Control Program, 11 State House Station, Augusta, ME 04333-0011

OFFICE USE ONLY:

FACILITY ID #: _____

EXPIRATION DATE: _____

Questions ? Call 207-287-5676 or email radiation.dhhs@maine.gov

HHE-805Facility (11/2017)