RADIATION PRODUCING EQUIPMENT REGISTRATION APPLICATION INSTRUCTIONS

To all new dental, podiatric, and veterinary facilities:
Such facilities shall be prohibited from commencing any clinical usage of radiation-producing equipment until it has been inspected by the Department or its agent; corrected all deficiencies noted at the time of such inspection; and has received a current registration.
Dental and podiatric facilities must contact a DOHMH certified CRESO to secure this inspection.
Veterinary facilities must contact the DOHMH Office of Radiological Health to schedule this inspection.

To applicants excluding dental, podiatric and veterinary facilities:
All such facilities in addition to a completed application form must submit a medical physicist report detailing the results of initial quality control tests conducted on all radiation-producing equipment in the facility. In this context, the initial quality control tests shall be the sum of all quality control tests mandated to be conducted for the facility type at daily, weekly, monthly, semiannual, annual and biennial frequencies. In addition, a radiation protection survey shall be conducted for each room housing a radiographic unit. In this context, a medical physicist shall be an individual possessing a current, non-expired CRESO certification in New York State, or a license to practice the specialty of diagnostic medical physics in New York State.

YOUR APPLICATION WILL NOT BE PROCESSED AND WILL BE RETURNED IF THE REQUIREMENTS BELOW ARE NOT INCLUDED.

ALL APPLICANTS MUST SUBMIT THEIR CRESO REPORTS AND WORKERS’ COMPENSATION AND DISABILITY INSURANCE PROOF WITH COMPLETED APPLICATION.

If you don't submit workers’ compensation and disability insurance – you must complete and submit a certificate of Attestation of Exemption form – CE-200. You can obtain this form at HTTP://WWW.WCB.STATE.NY.US/CONTENT/MAIN/FORMS/CE200.APPLY.PDF

ALL COMPLETED & APPROVED APPLICATIONS:
WILL RECEIVE AN INVOICE LETTER REQUESTING PAYMENT OF $100.00 (CHECK OR MONEY ORDER)
PAYABLE TO NYC Department of Health and Mental Hygiene

PLEASE INCLUDE YOUR APPLICATION NUMBER

PLEASE MAIL CHECK TO:
OFFICE OF RADIOLICAL HEALTH
2 LAFAYETTE STREET, CN60
NEW YORK CITY, NY 10007
1. NAME & ADDRESS OF APPLICANT / FACILITY

Check all that apply

- Owner
- CEO Dr. Name: ___________________________ M ______ Surname ______________________
- Practitioner
- Corporation/Institution

Facility Name ________________________________________________________________

Billing Address _____________________________________________________________ □ Room □ Suite  ______ Basement  

Borough __________________ City __________________ State ______ Zip Code ________

Telephone ___________________________ Fax ________________________________

2. ADDRESS AND LOCATION OF RADIATION PRODUCING EQUIPMENT WILL BE USED

- Same as #1 above

Billing Address _____________________________________________________________ □ Room □ Suite ____________

Borough __________________ City __________________ State ______ Zip Code ________

- Mobile Van  Vin # for the Van ________________________________________________

Email ________________________________

3. OFFICE HOURS & EXPECTED START DATE OF OPERATION

HOURS __________ A.M. / P.M. TO __________ A.M. / P.M.

DAYS:  SUN / MON / TUE / WED / TH / FRI / SAT

EXPECTED START DATE ________________________________________________________

4. RADIATION SAFETY OFFICER

SAME AS  □ OWNER/CEO  □ DR.

NAME ______________________________ M ______ SURNAME ________________________
5. INTERPRETING PHYSICIAN(S). INCLUDE ALL PHYSICIANS (for additional, copy this sheet)

a. Dr. ____________________________ M __ LAST ____________________________

b. Dr. ____________________________ M __ LAST ____________________________

c. Dr. ____________________________ M __ LAST ____________________________

d. Dr. ____________________________ M __ LAST ____________________________

e. Dr. ____________________________ M __ LAST ____________________________

6. EQUIPMENT TYPE & TUBES

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<tr>
<th>EQUIPMENT TYPE</th>
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<tbody>
<tr>
<td>Radiographic</td>
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<td>Mobile C-Arm</td>
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<td>Grenz Ray and Superficial Therapeutic</td>
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<td>Fluoroscopic</td>
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<td>Fluoroscopic</td>
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<td>CT-Scanner</td>
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<td>Fluoroscopic</td>
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<td>Dental</td>
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<td>Cabinet Fluoroscopic</td>
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<td>Mobile Radiographic</td>
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<td>Veterinarian</td>
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<td>Bone Densitometer</td>
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<td>Other (Please indicate type)</td>
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Type of Practice ____________________________

______________________________

DATE ____________________________

7. CERTIFICATION (MUST BE SIGNED BY THE APPLICANT)

X ____________________________

DATE ____________________________
Variance for hand held radiation producing equipment

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<th>Facility Name:</th>
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<tr>
<th>Registration No.</th>
<th>CAMIS ID</th>
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<tr>
<th>Manufacturer/Model/Serial #</th>
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<th>kVp</th>
<th>mA</th>
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I request a conditional variances from Sections 175.54(c)(2)(i) and 175.58(b)(7)(ii) of the New York City Health Code in order to operate a hand-held x-ray unit in special situations where it is not otherwise possible to use a fixed or mobile dental x-ray unit. I confirm that the following conditions will be met when the x-ray unit is operated:

1. This unit is operated by authorized personnel who have been trained in the operation of the device.
2. Any personnel operating the hand held unit must have their exposure to radiation monitored.
3. The hand held unit is only operated with the scatter shield in place.
4. When not in use the hand held unit is secured to prevent inadvertent exposures or use by unauthorized personnel.
5. All operators shall have read and print their name on this document prior to its use.
6. Copy of this document shall be posted at the radiographic site.

I agree to the above condition of use and will limit use of the device special situations. I understand that failure to follow these conditions may result in actions by the Department including revocation of this variance and/or fines.

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<th>Signature (Registrant)</th>
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Print Name

*Department of Health use only below this line*

Your request for variances from Sections 175.54(c)(2)(i) and 175.58(b)(7)(ii) of the New York City Health Code in order to operate the above hand-held dental x-ray unit is hereby granted. This variance applies to the above listed registration only.

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<th>Director</th>
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*Gene Miskin*

Office of Radiological Health