Application for Registration and Instructions for

RTF Therapeutic X-Ray Equipment Facility

RI General Laws Chapter 23-1.3

Registrant Name: _____

Registration Number: RTF

Reason for application (Please check all that apply):

1. ☐ Initial Registration
2. ☐ Change of address: What is your current registration number:_____
3. ☐ Change of ownership: What is your current registration number:_____
4. ☐ Registrant Name Change: _____

For Agency Use Only	Category: ___RTF_____ Registration No.: _____ Conditions: _____ Reviewed By: _____ Date: _____ Amount Paid: _____ Number of Active X-Ray Tubes: _____ Number of X-Ray Tubes in Storage: _____

State of Rhode Island
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your registration will not be issued. Please use a ball point pen.
- The fee for this registration application is $1350 made payable to: RI General Treasurer
- Sign the completed application and return to:

  Radiation Control Program
  Center for Health Facilities Regulation
  Rhode Island Department of Health
  3 Capitol Hill, Room 305
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the Radiation Control Program at (401) 222-2566.
- Registration application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Processing: For expedited processing of your registration, a valid email address must be provided wherever requested.

Attachments: X-Ray Facility registration applications require an attached shielding plan and evaluation. Please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Facility Supervisor Information: Please provide the name of the Facility Supervisor for this facility.	Name: _____ Registration Number: MD _____ Email Address: _____ Phone Number: _____
Individual Responsible for Radiation Protection:	Name: _____ Phone Number: _____ Title: _____ Email Address: _____

Facility Name: Please provide the name of the facility (as known to the public).	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Email Address: _____ Phone Number: _____

Facility Mailing Information: Please provide the mailing information for all communication regarding this registration. (**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: _____
Facility Location Information: 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: _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Partner ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership
Ownership Information: (Registrant) Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ (Registration Holder) DBA: _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone: _____ Fax: _____ Email Address: _____

State of Rhode Island
Department of Health

Qualified Medical Physicist:

Name: _____

RI Registration #: RPS _____

Therapeutic Radiation Machines utilized at the Facility Are:

Please select all applicable items.

☐ **00**. None – Equipment Stored
Number of Tubes: _____

☐ **41.** 5-50 kV System
Number of Tubes: _____

☐ **42.** >50 and <500 kV System
Number of Tubes: _____

☐ **43.** Photon Therapy System
Number of Tubes: _____

☐ **44.** Electron Therapy System
Number of Tubes: _____

☐ **45**. Electronic Brachytherapy
Number of Tubes: _____

☐ **46**. Simulator - R/F
Number of Tubes: _____

☐ **47**. Simulator - Cone Beam CT
Number of Tubes: _____

☐ **48**. Other Unit(s) (Specify) : _____
Number of Tubes: _____

Total Number of Tubes : _____

Therapeutic X-Ray Systems Information: Provide the requested information for each therapeutic X-ray system at the facility

Diagnostic X-Ray Systems Information: Provide the requested information for each diagnostic X-ray system at the facility (Please include OBIs and non-therapeutic X-ray systems used at the facility)

Unit #*	Manufacturer	Model	Energy(s)	Location	# of Tubes	Use**
						43

* Unit # used to identify X-ray equipment should also be used to identify that same X-ray equipment in the shielding evaluation.

** Use: Indicate the use of the equipment by inserting the number of the procedure listed

[***Continue on plain 8½" by 11" paper if necessary.***]

Shielding Evaluation

Therapeutic radiation machines also require submission of a shielding evaluation and documentation of compliance with § 5.9 of 216-RICR-40-20, *Radiation* for each location/unit.
[***Continue on plain 8½" by 11" paper if necessary.***]

Operating Personnel:	Identify all individuals who will be authorized to operate the therapeutic radiation machine(s). Provide documentation of compliance with § 5.3.5 of 216-RICR-40-20, *Radiation* for each individual. [***Continue on plain 8½" by 11" paper if necessary.***]
Dosimetry Service:	Identify the dosimetry service provider to be used at the facility:

Acknowledgements

I am aware of Chapter 23-1.3 of the General Laws of Rhode Island, 1978, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Agency shall, in conformity with the authority continued under Chapter 23-1.3 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any registration, 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 SSN/FEIN for this registration: SSN/F.E.I.N. Number: _____
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed by the Facility Supervisor** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this Registration in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** _____ _____ **Signature of Authorized Person** **Date of Signature (MM/DD/YY)** _____ **Printed Name of Authorized Person** _____ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.**