DEPARTMENT OF ENVIRONMENTAL QUALITY
OFFICE OF ENVIRONMENTAL COMPLIANCE
LICENSING & REGISTRATIONS SECTION
POST OFFICE BOX 4312
BATON ROUGE, LOUISIANA 70821-4312
PHONE: (225) 219-3041
E-MAIL:LDEQRadiationlicensing@la.gov

Office Use Only
APPLICATION
AI#
Registration No.
Shielding Date

APPLICATION FOR REGISTRATION OF RADIATION SOURCE

DRC-6 (3/21)

Must check all that apply:

☐ New Registration ☐ Shielding Evaluation Information (see pg 2) ☐ If replacing old machine enter old Registration # _____

☐ Change of Address or other Information (see pg 2) ☐ Disposition of Equipment, ie. required information if this unit replaces an existing one (See pg 3)

FACILITY INFORMATION

1. Company Name/Facility Name		2. Name of Owner	
3. Mailing Address: No. & Street	City & State	Zip Code	4. Contact Email Address
5. Billing Address: No. & Street	City & State	Zip Code	6. Area Code-Telephone Number of Facility
7. Full Address at which x-ray unit will be used		Parish	8. Room No. & Location where source will be used

9. Type of Facility

☐ Hospital (IM) ☐ Medical Clinic (PM) ☐ Private Medical Practice (PM) ☐ Educational Institution (ED)
☐ Industrial (IN) ☐ Industrial Radiography (IR) ☐ Private Dental Practice (PD) ☐ Other (Specify):_____
☐ Veterinary (VT) ☐ Chiropractic (DC) ☐ Dental Clinic (PD)

USER INFORMATION

10. Individual in Charge of Source (RSO, operator, etc.)	11. Individual Responsible for Radiation Protection

12. Classification of Individual in Charge of Source

☐ Dentist ☐ General Practitioner ☐ Health Physicist ☐ Registered X-Ray Technologist
☐ Radiologist ☐ Industrial Radiographer ☐ Veterinarian ☐ Non-Registered X-Ray Tech.
☐ Chiropractor ☐ Podiatrist ☐ Osteopath ☐ Other (Specify):_____

SOURCE INFORMATION

13. Source

A. Medical X-Ray
☐ Fluoroscopic w/ Image Intensifier
☐ Fluoroscopic w/o Image Intensifier
☐ Combination *w/ Image Intensifier
☐ Combination *w/o Image Intensifier
☐ Radiographic
☐ Photofluorographic
☐ Mammography
☐ CT ☐ CT For Non-Diagnostic Use Only
*Radiographic & Fluoroscopic Combination

☐ Bone Densitometer
☐ Deep Therapy
☐ Superficial Therapy
☐ Special Procedures

B. Dental X-Ray
☐ Conventional
☐ Panoramic
☐ Cephalometric
☐ CBCT (see shielding pg 2)

C. Accelerator
☐ Neutron Generator
☐ Van de Graaff
☐ Linear Accelerator

D. Other X-Ray
☐ Industrial Radiography
☐ Diffraction Apparatus
☐ Cabinet
☐ Other (Specify): _____

E. Educational Institution
☐ Medical X-Ray
☐ Dental X-Ray
☐ Other X-Ray

F. Veterinary
☐ Radiographic
☐ Dental

14. Source is: ☐Fixed ☐Mobile ☐Handheld (If handheld, attach training documentation from the manufacturer)

15. **Control Panel Information (Use one form for each panel):** *Use only information from Control Panel*

a. Manufacturer	b. Model Number	c. Serial Number	d. Number of Tube Heads	e. Max. kVp	f. Max. mA

CERTIFICATION

16. This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

_____	_____	_____	_____
Date	Primary Contact Person (Print)	Applicant (Print)	Signature of Responsible Party

Submit the completed original application for each x-ray unit to the above address or email LDEQRadiationlicensing@la.gov, and maintain a copy for your files.

Shielding Evaluation Information

LAC 33:XV.603.E. Plans Review

1. Except for dedicated mammography radiographic systems, podiatric radiographic systems, panoramic dental radiographic systems, and intraoral dental radiographic systems, prior to construction, the floor plans and equipment arrangement of **all new installations, or modifications of existing installations, utilizing X-rays for diagnostic or therapeutic purposes shall be submitted to the Office of Environmental Compliance for review and approval.** The required information is specified in LAC 33:XV.699.Appendices A and B.
2. The floor plans and equipment arrangement for all new, or modifications of existing, installations for veterinary X-ray systems shall be reviewed for adequacy by the department on a case-by-case basis.

*If shielding is required for X-ray unit and has already been approved by the Department **please attach a copy of the approval letter**. If letter is not available, submit the following information:*

Room Housing Unit (Description or Room Number):	Date of the Department approved shielding:	☐ Shielding review form enclosed ☐ Shielding review form recently submitted and waiting for approval

*If the machine to be registered requires shielding and it is replacing an old machine that already had a shielding review done or it is a **CBCT unit**, please submit the following information:*

Average # of Patients/week:	Average kVp used:	☐ Room has not changed since last approved shielding review ☐ Room has changed since last approved shielding review (please enclosed description of changes) ☐ CBCT Unit is placed in a room

If the above information is not available, please submit a physicist survey

☐ Physicist Survey included
☐ Physicist Survey not included

For CBCT units, please submit training certificate(s) and Quality Assurance Plan

Please provide any other detailed information that will assist the department in registering your machine(s).

_____

_____

_____

_____

_____

Transfer Information

If facility/machines were transferred from a different location that the registrant owns, please provide the following information for ***the previous location, the new location, and which machines are being transferred.***

PREVIOUS FACILITY INFORMATION		
1. Company Name/Facility Name	2. Name of Owner	3. Agency Interest No., if known
4. Full Address at which x-ray was located:	5. Telephone Number of Facility	6. Contact Email Address

NEW FACILITY INFORMATION			
1. Company Name/Facility Name		2. Name of Owner	3. Agency Interest No., if known
4. Mailing Address: No. & Street	City & State	Zip Code	5. Contact Email Address
6. Billing Address: No. & Street	City & State	Zip Code	7. Area Code – Telephone Number of Facility
8. Address at which x-ray is located:	City & State	Zip Code	9. Date of Transfer

SOURCE INFORMATION

Control Panel Information **(Use a separate page for additional units):** *Use only information from Control Panel*

a. Manufacturer	b. Model Number	c. Serial Number	d. Type of Machine

NOTE: *For any unit that requires shielding, please refer to Shielding Evaluation Information (page 2) for the new location.*

CERTIFICATION

This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

_____	_____	_____	_____
Date	Primary Contact Person (Print)	Applicant (Print)	Signature of Responsible Party

NOTE: All applications must be signed and dated before a Registration Certificate can be issued.

RADIATION MACHINE DISPOSITION FORM

TO AVOID PAYING A FEE ON A RADIATION MACHINE THAT IS NO LONGER IN YOUR POSSESSION OR INOPERABLE IN THE MANNER DESCRIBED BELOW, THE FOLLOWING REQUESTED INFORMATION **MUST BE RECEIVED BY THE DEPARTMENT BY THE INVOICE DUE DATE.**

Registration No. of radiation machine no longer in your possession or deemed inoperable: _____

Manufacturer of above machine: _____

Model Number: _____

Serial number: _____

If machine was transferred, list person/company and address that machine was transferred to:

_____

_____

_____

Indicate if machine is "Inoperable" in the manner listed below: ☐ YES ☐ NO

A machine is inoperable only if the machine's X-ray tube (insert) has been removed in such a manner that it would require an X-ray company/service person to make it operable. With the X-ray tube in place, the unit is considered to be operable.

If you have any questions, please contact the Department at (225) 219-3041.

_____
AGENCY INTEREST ID
(if known)

_____
Date

_____
Contact Number

_____
NAME OF APPLICANT

_____
Name of Facility/Doctor/Company

_____
Address