DEPARTMENT OF ENVIRONMENTAL QUALITY
OFFICE OF ENVIRONMENTAL COMPLIANCE
LICENSING & REGISTRATIONS SECTION
POST OFFICE BOX 4312
BATON ROUGE, LOUISIANA 70821-4312
PHONE: (225) 219-3041 FAX: (225) 219-3154

Office Use Only
APPLICATION
AI#
Registration No.
Shielding Date

APPLICATION FOR REGISTRATION OF RADIATION SOURCE

DRC-6 (2/10)

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 Parish

4. Billing Address: No. & Street City & State Zip Code Parish

5. Address at which x-ray unit will be used	6. Area Code-Telephone Number of Facility	7. Room No. & Location where source will be used

8. 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

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

11. 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

12. Source **(Application fee shall be submitted with the Application)**

A. Medical X-Ray (App. fee $117)
☐ Fluoroscopic w/ Image Intensifier
☐ Fluoroscopic w/o Image Intensifier
☐ Combination *w/ Image Intensifier
☐ Combination *w/o Image Intensifier
☐ Radiographic
☐ Photofluorographic
☐ Mammography
☐ CT
*Radiographic & Fluoroscopic Combination

☐ Bone Densitometer
☐ Deep Therapy **(call for App. Fee)**
☐ Superficial Therapy **(call for App. Fee)**
☐ Special Procedures **(call for App. Fee)**

B. Dental X-Ray (App. Fee $104)
☐ Conventional
☐ Panoramic
☐ Cephalometric

C. Accelerator: (call for App. Fee)
☐ Neutron Generator
☐ Van de Graaff
☐ Linear Accelerator

D. Other X-Ray
☐ Industrial Radiography**(App. Fee $277)**
☐ Diffraction Apparatus **(App. Fee $125)**
☐ Cabinet **(App. Fee $125)**
☐ Other (Specify)_____

E. Educational Institution (App fee. $172)
☐ Medical X-Ray
☐ Dental X-Ray
☐ Other X-Ray

F. Veterinary (App. Fee $104)
☐ Radiographic

13. Source is: ☐Fixed ☐Mobile ☐Handheld (attach training documentation from the manufacturer)

14. **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

15. 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, and maintain a copy for your files.

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

Shielding Evaluation Information

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, 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)

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

- ☐ Physicist Survey included
- ☐ Physicist Survey not included

Transfer Information

If facility/machines were transferred from a different location, please provide the following information for the previous location.

FACILITY INFORMATION			
1. Company Name/Facility Name		2. Name of Owner	
3. Mailing Address: No. & Street	City & State	Zip Code	Parish
4. Billing Address: No. & Street	City & State	Zip Code	Parish
5. Address at which x-ray unit will be used		6. Area Code-Telephone Number of Facility	7. Date of Transfer

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

_____

_____

_____

_____

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)

_____ NAME OF APPLICANT

_____ DATE