



Minnesota Department of Health
Initial Registration of Ionizing Radiation-Producing Equipment
 (See instructions for completing form)

Facility Name:		Registration Number:	
Facility Address:		Federal Tax ID Number	State Tax ID Number
		Facility Telephone Number:	Facility Fax Number
Facility Email:			
Type of Facility: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Educational <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office <input type="checkbox"/> Portable X-ray Service <input type="checkbox"/> Veterinary <input type="checkbox"/> Dental <input type="checkbox"/> Government <input type="checkbox"/> Industrial <input type="checkbox"/> Podiatry <input type="checkbox"/> Radiation Therapy			
Facility Administrator:		Administrator Telephone Number:	
Facility Radiation Safety Officer:		RSO Telephone Number:	

Quality Assurance/Quality Control Program in Place: Yes No
Installation Calibration completed: Date: _____ **Company:** _____

NEW CONTROL CONSOLE INFORMATION						
Console Type	Manufacturer	Model Name/Number	Serial Number	Console Location	Max kVp	Max mA or mAs
Tube Type		Tube Manufacturer		Tube Head Serial Number		

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Tube Type		Tube Manufacturer		Tube Head Serial Number		

I understand the applicable requirements of Minnesota Rules, Chapter 4732, Ionizing Radiation. The information provided in this registration is correct to the best of my knowledge. I will notify the Minnesota Department of Health, Radiation Control Unit, immediately of any changes in this registration.

 Person responsible for administrative control of equipment

 Date

Instructions for completion of registration of new ionizing radiation-producing equipment

The registration form, when properly completed and filed with the Minnesota Department of Health, Radiation Control Unit, constitutes registration of x-ray machines or devices under Minnesota Rules, Chapter 4732, Ionizing Radiation. Complete registration consists of completed registration forms as described in 4732.0200 and fee payment as described in 4732.0210.

1. Please complete the applicable sections of this form.
2. Please make additional copies of the forms if necessary.
3. Console type (please list one of the following) :

Accelerator	Dental Radiographic	Medical Fluoroscopic	Veterinary Fluoroscopic
Bone Densitometer	Experimental Research	Medical Portable	Veterinary Radiography
Cabinet Radiography	Industrial Fluoroscopic	Medical Radiographic	Veterinary Therapy
C-Arm R/F	Industrial Radiographic	Medical Therapy	X-ray Diffraction
CT Scanner (Incl. Dental)	Lithotripsy	PET/CT	X-ray Fluorescent Analyzer
Cyclotron	Mammography	Veterinary Dental	Other (please specify)

4. Enter the manufacturer, serial number and tube serial number. If the console controls more than one tube, please fill in the information under the second box of the tube information.
5. Console location is the room name or number in which the console is located.
6. mA means the maximum milli amperage for the unit. kVp means the kilo voltage of the unit.
7. Tube type (Type of Use) (please list one of the following) :

Bone Densitometer	Extraoral	Lateral	Panoramic/Cephalometric
Cephalometric	Fluoroscopic	Linear Accelerator	Radiographic
C-Arm R/F	Industrial	Lithotripsy	Single Tube R/F
CT Scanner	Intraoral	Mammographic	Therapy
Digital	Intraoral/Cephalometric	Panoramic	Other (please specify)

8. If this is a replacement unit, be sure to list what unit was replaced. There is no fee required for a replacement unit.

Tube Type	Fee per Tube	Number of Tubes	Total Fee
Dental (including Veterinary Dental and Dental CT)	\$40.00		
Medical, Chiropractic, Veterinary, Industrial (Including CT, excluding Mammographic)	\$100.00		
Devices with sources of ionizing radiation not used on humans	\$100.00		
Accelerators and cyclotrons - single fee for all units	Med/Vet - \$500.00 Industrial - \$150.00		
Mammographic	\$53.00		
		Facility Base Fee	+ \$100.00
		Grand Total	

9. Please sign and date form.

BEFORE MAILING THE REGISTRATION FORMS, BE SURE TO:

- Fill out all applicable sections of the form.
- Sign and date the form.
- Enclose forms and check made payable to "Minnesota Department of Health".

MAIL TO: MN DEPARTMENT OF HEALTH
 RADIATION CONTROL
 625 ROBERT STREET NORTH
 P.O. BOX 64497
 ST. PAUL, MN 55164-0497

Questions call the Radiation Control Unit at 651-201-4545