Radiation Control
625 Robert Street North
P.O. Box 64975
St. Paul, Minnesota 55164-0975
Phone: 651-201-4545

(MDH Use Only)

Service Provider #:

Service Provider Registration Application

A. Applicant Information

Name: ______________________________
First Middle Initial Last

Home Address: ______________________________

City/State/Zip: ______________________________

Phone #: ________________ Email: ________________

B. Employment Information

Company Name: ______________________________

Business Address: ______________________________

City/State/Zip: ______________________________

Business Phone #: ________________ Fax #: ________________

C. Experience and Training

Experience (Please check all that apply. No additional paperwork needed.)

Years of Experience ____________

☐ Automatic Processors ☐ Bone Densitometry ☐ C-arms ☐ Computed Radiography
☐ CT Scanner ☐ Dental Extraoral ☐ Dental Intraoral ☐ Digital
☐ Fluoroscopic ☐ Industrial ☐ Mammographic ☐ Podiatry
☐ Radiographic ☐ Other (list) ______________________________

Training (List training not provided above. Verification should be kept on file with your employer.)

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D. Manufacturers

☐ Agfa	☐ Axtech	☐ Belmont	☐ Bennett	☐ Continental
☐ CPI	☐ Del Medical	☐ Excel	☐ Fischer	☐ Gendex
☐ General Electric	☐ Hologic	☐ Icat/New Tome CT	☐ Instrumentarium	☐ Kodak
☐ Konica	☐ Lorad	☐ Lumix	☐ Midwest	☐ Mini X-ray
☐ Norland	☐ OEC	☐ Phillips	☐ Picker	☐ Planmeca
☐ Prodigy	☐ Progeny	☐ Quantum	☐ Ritter	☐ Schick
☐ Sedecal	☐ Siemens	☐ Sirona	☐ SS White	☐ Summit
☐ Toshiba	☐ Traceray	☐ Transworld	☐ Universal	☐ Weber

☐ Other (list) ____

E. Services

☐ Diagnostic	☐ Equipment Performance Evaluations	☐ Industrial
☐ Installation Calibration	☐ Installation of Equipment	☐ Quality Control Tests
☐ Repairing of Equipment	☐ Shielding Plans	☐ Verification Tests

☐ Other (list) ____

F. Signature

I declare that all the information I have provided is true and complete and that I have read and understand the department's "Tennessen Warning." We are requesting your name, address and phone number so that we may contact you for further information relating to your service provider registration and renewal. You are not required to provide this information. However, without it we will not be able to contact you regarding additional information that may be needed or for renewal of the registration. All information you provide is legally classified as confidential data for individuals and can only be released to Minnesota Department of Health employees as needed to process renewal registration and anyone having a court order to obtain the information.

Applicant's Signature ______________________________ Date ______________

Before mailing, be sure to:

- Fill out all applicable sections of the application.
- Sign and date the application.
- Review and make any necessary changes
- Include email address to receive our monthly X-ray Bulletin or future renewals

MAIL TO: ADDRESS ABOVE
FAX TO: 651-201-4606