DEPARTMENT OF HEALTH

(MDH Use Only)
Service provider# _____

Service Provider Registration Application

Applicant Information

Name: _____
First Middle Initial Last

Home Address: _____

City/State/Zip: _____

Phone #: _____ Email: _____

Employment Information

Company Name: _____

Business Address: _____

City/State/Zip: _____

Business Phone #: _____ Email: _____

Credential (according to MN Statue 144.121) (Please check all that apply.)

☐ Service Technician ☐ Vendor ☐ Qualified Medical Physicist
☐ Qualified Expert ☐ Physicist Assistant

Experience and Training

Experience (Please check all that apply. Use additional paper if necessary.)

Years of Experience _____

☐ Automatic Processors ☐ Bone Densitometry ☐ C-arms ☐ Computed Radiography
☐ CT Installation ☐ CT Physics Testing ☐ Dental Extraoral ☐ Dental Intraoral
☐ Digital ☐ Fluoroscopic ☐ Industrial ☐ Mammographic
☐ Podiatry ☐ Radiographic ☐ Shielding Plans ☐ Radiation Surveys
☐ Dental CBCT ☐ Medical CBCT ☐ Superficial Therapy ☐ Radiation Therapy
☐ Other (list) _____

Training (List specific training, providers and dates. Use additional paper if necessary. Physicist Assistants must provide documentation of the supervising qualified expert or qualified medical physicist.)

_____

_____

_____

_____

_____

_____

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) _____

Services

☐ Diagnostic	☐ Equipment Performance Evaluations	☐ Industrial
☐ Installation Calibration	☐ Installation of Equipment	☐ Quality Control Tests
☐ Repairing of Equipment	☐ Shielding Plans	☐ Verification Tests
☐ Radiation Survey	☐ Preventive Maintenance	☐ Vendor

☐ Other (list) _____

Fees Due with Application

$115.00 MDH Processing Fee. Cashier's check/money order attached. Your application will not be processed with a personal or business check. Mail to address below.

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 Signature _____ Date _____

Before submitting the application, be sure to:

1. Fill out all applicable sections of the application.
2. Include email address.
3. Sign and date the application.
4. Include $115.00 fee, cashier's check or money order.

Submit to:

Minnesota Department of Health
Radiation Control, X-ray Unit
625 Roberts St N
PO Box 64497
St. Paul, MN 55164-0497
651-201-4545
health.xray@state.mn.us
www.health.state.mn.us

08/04/25

To obtain this information in a different format, call: 651-201-4545.