Radiation Control Program

MAMMOGRAPHER TERMINATION REQUEST

MAMMOGRAPHER NAME:_____

MAMMOGRAPHER CERTIFICATE NO: _____ TELEPHONE NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COMPLETED NECESSARY INFORMATION

DATE TERMINATION REQUEST SUBMITTED: _____

REASON FOR TERMINATION: _____

DATE FIRST QUALIFIED: _____

The undersigned, registrant or on behalf of the registrant, hereby requests that the registration for the above-referenced Mammographer be terminated.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

Please return completed signed form to:

Nevada State Division of Public and Behavioral Health
Radiation Control Program
675 Fairview Drive, Suite 218
Carson City, NV 89701