



Radiation Producing Machine



Registration Form

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NAME OF FACILITY	PREVIOUS REGISTRATION No.	TELEPHONE	FAX No.
<hr/>	<hr/>	<hr/>	<hr/>
STREET ADDRESS	CITY	STATE	ZIP
<hr/>	<hr/>	<hr/>	<hr/>
ADDRESS WHERE MACHINE WILL BE USED (IF DIFFERENT)	CITY	STATE	ZIP
<hr/>	<hr/>	<hr/>	<hr/>
WAS THIS MACHINE STORED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WILL THE MACHINE BE USED STATEWIDE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<hr/>	<hr/>	<hr/>	<hr/>
NAME OF PERSON RESPONSIBLE FOR RADIATION SAFETY	TITLE	E-MAIL ADDRESS	
<hr/>	<hr/>	<hr/>	
IS THIS A LICENSED ACADEMIC INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HAVE ALL INVOLVED PERSONNEL RECEIVED TRAINING IN SAFE INJECTION PRACTICES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
MACHINE INFORMATION (ONE MACHINE PER APPLICATION)			
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MANUFACTURER	MODEL No.	CONTROL PANEL SERIAL NUMBER	# OF TUBES
HUMAN MEDICAL RADIATION PRODUCING MACHINE			
<input type="checkbox"/> Stereotactic	<input type="checkbox"/> Radiographic – Stationary	<input type="checkbox"/> Radiographic – Mobile and Portable	
<input type="checkbox"/> Combination Radiographic & Fluoroscopic	<input type="checkbox"/> C-arm – fixed	<input type="checkbox"/> Cabinet Biopsy Machine	
<input type="checkbox"/> DEXA – Bone Density	<input type="checkbox"/> C-arm - Mobile	<input type="checkbox"/> Other: _____	
CT – ALL COMPUTED TOMOGRAPHY (INCLUDING BUT NOT LIMITED TO: WHOLE BODY, EXTREMITIES, HEAD, FACE AND NECK)			
<input type="checkbox"/> CT			
HUMAN DENTAL RADIATION PRODUCING MACHINE			
<input type="checkbox"/> Panoramic	<input type="checkbox"/> Cephalometric	<input type="checkbox"/> Handheld	
<input type="checkbox"/> Intraoral	<input type="checkbox"/> Other: _____		
ACCELERATOR (MEDICAL/NON-MEDICAL)			
<input type="checkbox"/> Therapy <input type="checkbox"/> Particle	Maximum Potential MeV*		
<i>*If the maximum operating output is more than 8 MeV, please contact us for assistance</i>			
NON-HUMAN / NON-MEDICAL			
<input type="checkbox"/> Industrial Security/Baggage	<input type="checkbox"/> Industrial Cabinet	<input type="checkbox"/> Industrial Radiography (fixed port)	
<input type="checkbox"/> Industrial Fluoroscopic	<input type="checkbox"/> Analytical Diffraction Apparatus	<input type="checkbox"/> Electron Microscope	
<input type="checkbox"/> Academic	<input type="checkbox"/> Other: _____		
VETERINARY MEDICAL			
<input type="checkbox"/> Radiographic Fixed	<input type="checkbox"/> Radiographic Mobile	<input type="checkbox"/> Radiographic Portable	
<input type="checkbox"/> Handheld	<input type="checkbox"/> Dental (Fixed/Mobile)	<input type="checkbox"/> Fluoroscopic (Fixed/Mobile)	
Submit Items below with this Application:			
<input type="checkbox"/> Enclose the fee, check payable to STATE OF NEVADA – RADIATION CONTROL PROGRAM		Amount Enclosed: \$ _____	
<input type="checkbox"/> (RADIATION PRODUCING MACHINES NAC 459.161 & MAMMOGRAPHY FEES NAC 457.295)			
<input type="checkbox"/> Enclose a copy of the State or local government Business License			
To the best of my knowledge and belief, all information contained herein is true and correct			
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ADMINISTRATOR'S SIGNATURE	PRINTED NAME	TITLE	DATE
Form must be signed or no action will be taken. Applications that have SATISFIED ALL REQUIREMENTS may take up to two weeks to process.			
FOR OFFICIAL USE ONLY			
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REGISTRATION NUMBER	DATE PROCESSED	EXPIRATION DATE	INITIALS

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