



Radiation Producing Machine



Registration Form

| | | | |
|---|---------------------------|----------------|---------|
| NAME OF FACILITY | PREVIOUS REGISTRATION No. | TELEPHONE | FAX No. |
| STREET ADDRESS | CITY | STATE | ZIP |
| ADDRESS WHERE MACHINE WILL BE USED (IF DIFFERENT) | CITY | STATE | ZIP |
| 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 | | | |
| NAME OF PERSON RESPONSIBLE FOR RADIATION SAFETY | TITLE | E-MAIL ADDRESS | |
| 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)

| | | | |
|---|---|--|------------|
| 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 required items below with this application for processing:

- Enclose a copy of the State or Local Government Business License
- Enclose the FEE, check payable to STATE OF NEVADA – RADIATION CONTROL PROGRAM
- NONREFUNDABLE RADIATION PRODUCING MACHINES FEES NAC 459.161 & MAMMOGRAPHY FEES NAC 457.295

Amount Enclosed: \$ _____

To the best of my knowledge and belief, all information contained herein is true and correct

| | | | |
|---------------------------|--------------|-------|------|
| 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

| | | | |
|---------------------|----------------|-----------------|----------|
| REGISTRATION NUMBER | DATE PROCESSED | EXPIRATION DATE | INITIALS |
|---------------------|----------------|-----------------|----------|