



RADIATION MACHINE REGISTRATION APPLICATION PART A - GENERAL FACILITY INFORMATION AND AGREEMENT

State Form 9977 (R5 / 2-10)
INDIANA STATE DEPARTMENT OF HEALTH
MEDICAL RADIOLOGY SERVICES

FOR OFFICIAL USE ONLY: New Facility Update Facility (*new machine, new location, etc.*) Routine Inspection

In accordance with regulations promulgated under authority of IC 16-41-35, each person having one or more radiation machines shall apply for registration of the machines with the Indiana State Department of Health before the operation of the machines. This registration must also be updated whenever the information contained in it changes.

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION.

FACILITY INFORMATION

If the facility has no name, list the doctor's name. If the mailing address is different than the physical address of the facility, list both addresses, clearly indicating which is the mailing address and which is the physical address. The radiation safety officer must be an employee of the facility and is the individual responsible for radiation safety at the facility in case of overexposures or other problems. If this is a previously unregistered facility, put "New" for the Facility Registration number.

Facility Registration number	Name of facility	Date (<i>month, day, year</i>)
------------------------------	------------------	----------------------------------

Address (*number and street*)

City, state, and ZIP code

Facility telephone number ()	County of practice
--	--------------------

Name of Radiation Safety Officer (RSO)	RSO telephone number ()
--	-----------------------------------

Select type of facility:

<input type="checkbox"/> X - Dental	<input type="checkbox"/> 3 - Educational (<i>Schools / Colleges</i>)	<input type="checkbox"/> 6 - Veterinarian
<input type="checkbox"/> 1 - Hospital	<input type="checkbox"/> 4 - Podiatric	<input type="checkbox"/> 7 - Industrial
<input type="checkbox"/> 2 - Physicians / Clinics / Mobile	<input type="checkbox"/> 5 - Chiropractic	<input type="checkbox"/> 8 - Nursing Homes / Other _____

REGISTRATION AGREEMENT

The following agreement should be signed by a person who has legal responsibility for the radiation machines at the facility (i.e., owner, hospital administrator, corporation director, etc.)

I understand that failure to comply with IC 16-41-35 or 410 IAC 5 may result in revocation of my machine registration.

Printed name of responsible individual

Signature of responsible individual	Date (<i>month, day, year</i>)
-------------------------------------	----------------------------------

Return Parts A, B and C of this application to:

**Indiana State Department of Health
Medical Radiology Services
2 North Meridian Street, 5-F
Indianapolis, IN 46204-3010**

If you have any questions, call 317/233-7147 and ask for the Radiation Machine Program Coordinator.



RADIATION MACHINE REGISTRATION APPLICATION PART B - SPECIFIC FACILITY INFORMATION

Part of State Form 9977 (R5 / 2-10)
INDIANA STATE DEPARTMENT OF HEALTH
MEDICAL RADIOLOGY SERVICES

PERSONNEL RADIATION EXPOSURE MONITORING (All Facilities)

Name of personnel monitoring device supplier	Types of personnel monitoring devices used
Number of persons monitored for WHOLE BODY exposure	
Number of persons monitored for EXTREMITY exposure	
Number of persons monitored under eighteen (18) years of age	

MAMMOGRAPHY FACILITY STAFF QUALIFICATIONS (Mammography Facilities Only)

Interpreting Physician Requirements

Are all interpreting physicians ABR, AOBR, or ACR certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all interpreting physicians completed or taught 40 hours of postgraduate instruction in mammography interpretation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all interpreting physicians completed or taught 15 hours minimum postgraduate work in mammography interpretation in the past 36 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do all interpreting physicians read at least 10 mammography exams per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do all interpreting physicians provide written statements as required by 410 IAC 5-6.1-127?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Consulting Physician Requirements

Does the consulting physician meet all the requirements of an interpreting physician as listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the consulting physician check the procedures manual annually?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the consulting physician verify the performance of the mammography machines and mammographers monthly?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mammographer Requirements

Are all mammographers Indiana state certified diagnostic x-ray machine operators in the "General" category?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers completed at least 10 hours of continuing education in mammography in the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers passed the ARRT Mammography examination or completed 10 hours of specialized training in mammography (positioning, compression, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers completed an orientation program based on the procedures manual?	<input type="checkbox"/> Yes <input type="checkbox"/> No

STAFF QUALIFICATIONS (Human Use Facilities Only [Medical, Hospital, Chiropractic, Podiatric, Dental, etc.]

List the number of each of the following types of personnel employed by the facility.

Licensed Practitioners	Dental Hygienists	Students in approved education programs
State Certified Diagnostic X-Ray Machine Operators	Other persons taking radiographs	



RADIATION MACHINE REGISTRATION APPLICATION PART C - RADIATION MACHINE INFORMATION

Part of State Form 9977 (R5 / 2-10)
INDIANA STATE DEPARTMENT OF HEALTH
MEDICAL RADIOLOGY SERVICES

FACILITY INFORMATION

Date (month, day, year)	Facility regulation number (from Part A)	Name of facility (from Part A)	Page number
			_____ of _____ pages

MACHINE INFORMATION

List each radiation machine in your facility on a separate line in the table and provide all information requested.

Tube Number	Type of Machine (Code from table below)	Location in Facility (Room Number)	Machine Control Manufacturer	Number of Tube Heads	Beam Collimation (Check Only One)	Maximum kVp rating	Maximum mA rating	Utilization Mode (Check Only One)	Date Manufactured	Date Installed
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> None <input type="checkbox"/> Cone <input type="checkbox"/> Other <input type="checkbox"/> Diaphragm			<input type="checkbox"/> Fixed <input type="checkbox"/> Not in use <input type="checkbox"/> Mobile <input type="checkbox"/> Portable		

Radiation Machine Type Codes:

- 1 Therapy Simulator
- 2 Superficial X-ray Therapy (up to 150 kV)
- 3 Cobalt-60 Therapy
- 4 Electron Beam Only Therapy
- 5 Supervoltage Therapy (1-11.99 MEV)
- 6 Megavoltage Therapy (12+ MEV)
- 7 Orthovoltage Therapy (151-999 kV)

- 8 Particle Accelerator
- 9 Tomography
- 10 Computer Tomography (Head)
- 11 Computer Tomography (Body)
- 12 Radiography
- 13 Mammography
- 14 Digital Radiography

- 15 Fluoroscopy (undertable)
- 16 Fluoroscopy (abovetable)
- 17 Fluoroscopy / Radiography
- 18 C-Arm Fluoroscopy
- 19 MRI Unit
- 20 Dental, Cephalometric
- 21 Dental, Intraoral

- 22 Dental, Panoramic
- 23 Dental, Multipurpose
- 24 TMJ Unit
- 25 Mobile Van
- 26 Industrial X-ray
- 27 Laboratory X-ray
- 28 Other _____