INSTRUCTIONS FOR X-RAY REGISTRATION

In accordance with the Radiation Control Act, Chapter 31-13 of the Official Code of Georgia Annotated, and the Rules and Regulations for X-Ray, Chapter 290-5-22, users of radiation machines are required to be registered with the Department prior to the operation of X-ray equipment in Georgia. An approved registration requires submission of a registration application, an approved shielding design, and an initial inspection.

The Department will acknowledge receipt of all relevant materials. Disapproved shielding designs will be returned for modification. Facility registration is not transferable, however an approved shielding design for a specified facility may be used by a subsequent owner for registration purposes, provided x-ray use is within specified conditions. Relocations require a new application, shielding design and an initial inspection.

Be advised that: A FACILITY MAY NOT OPERATE X-RAY MACHINES UNTIL AN INITIAL INSPECTION IS DONE. FAILURE TO REGISTER YOUR MACHINES IN ACCORDANCE WITH REGULATIONS WILL CAUSE YOU TO BE SUBJECT TO CIVIL MONEY PENALTIES NOT TO EXCEED $1,000.00 OR DENIAL OF REGISTRATION OR BOTH. Due to a backlog of inspections, the X-ray Unit is approximately six weeks behind in completing initial inspections. If you wish to operate the X-ray equipment sooner, you may opt to have an individual qualified at § § 290-5-22-.02(1)(d) and .02(4) to perform the initial inspection at your own expense.

Enclosed is a package of information that contains forms and materials that you are required to submit to this Office within (30) days. The materials included are:

1. Rules and Regulations for X-Rays
2. Shielding Design Format Requirements with example
3. Reportable Incidents Instruction
4. Initial Inspection Form

Any questions concerning the requirements in this letter may be addressed by calling 404-657-5400. To aid you in completing the forms, directions are enclosed in your packet.
PERSONAL IDENTIFICATION REQUIREMENTS

All applications for state licensure and registration submitted after March 1, 2006 will require a notarized personal identification affidavit. This affidavit is for your X-ray facility. Please see the attached affidavit and list of documents that establish identity.

The application, shielding design and affidavit **must be mailed together**. Please do not fax. This will delay the registration process.

**Please mail the original to:**

Department of Community Health  
Healthcare Facility Regulation Division  
Health Care Section – Diagnostic Services  
2 Peachtree Street, NW, Suite 31-447  
Atlanta, GA 30303-3142  
Attention: **X-ray Unit**
PERSONALLY APPEARED before the undersigned officer, duly authorized to administer oaths, came the undersigned, who after having been duly sworn, states under oath, the following:

1. That my name is__________________________ and that I am who I say I am;
2. That my address is_______________________________________________;
3. That I have presented sufficient personal identification to the notary that is true and accurate;
4. That I am legally in the United States of America;
5. That I am applying to the Georgia Department of Community Health, Healthcare Facility Regulation Division, to operate a business/activity that is subject to regulation by the Department of Community Health; and that this affidavit is a material part of the application; and
6. That if the Department subsequently determines that the material information contained in this affidavit is false, I will be in violation of licensing/registration requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me

This _____ day of ________, _______.

_______________________________
Affiant

_______________________________
NOTARY PUBLIC

My commission expires: __________________________.
LIST B

Documents That Establish Identity

For individuals 18 years of age or older

- Driver’s license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
- ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form 1-179])
- School identification card with photograph
- Voter’s registration card
- United States military card or draft record
- Military dependent’s identification card
- United States Coast Guard Merchant Mariner Card
- Native American tribal document
- Driver’s license issued by a Canadian government authority


08/09
APPLICATION FOR X-RAY REGISTRATION

A. Applicant: ________________________________________________ Facility _____________________________________________

(Please Print or Type)

Facility Address: __________________________________________

Mailing Address: __________________________________________

County: ____________________________ Telephone (          ) _______________________________ Fax (          ) ______________________

B. Has a Radiation Shielding Design for this facility been submitted to the X-ray Unit for approval? A plan must be submitted as part of the initial registration requirements: [ ] Yes [ ] No If yes, plan review no. ___________________________

C. Is This Application for: (check all that apply) Have you previously registered an X-ray Facility in Georgia? [ ] Yes [ ] No

[ ] A new facility If yes, under what name: ____________________

[ ] Relocation

[ ] A purchase of new equipment

[ ] Update information of Previously registered

and in what county: ____________________

[ ] Other __________________________

D. Equipment type: (Indicate the number of machines in each category):

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<thead>
<tr>
<th>Equipment Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dental Intraoral</td>
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<td>2 Dental Cephalometric</td>
<td>2</td>
</tr>
<tr>
<td>3 Dental Panographic</td>
<td>3</td>
</tr>
<tr>
<td>4 Radiographic Only</td>
<td>4</td>
</tr>
<tr>
<td>5 Fluoroscopic Only</td>
<td>5</td>
</tr>
<tr>
<td>6 R &amp; F Same Unit No of tubes</td>
<td>6</td>
</tr>
<tr>
<td>7 Mammography</td>
<td>7</td>
</tr>
<tr>
<td>8 C-Arm</td>
<td>8</td>
</tr>
<tr>
<td>9 Computerized Tomography</td>
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<td>10 Photofluorographic</td>
<td>10</td>
</tr>
<tr>
<td>11 Analytical X-ray</td>
<td>11</td>
</tr>
<tr>
<td>12 Particle Analyzer</td>
<td>12</td>
</tr>
<tr>
<td>13 Therapeutic (less than 0.9 Mev)</td>
<td>13</td>
</tr>
<tr>
<td>14 Therapeutic Accelerator</td>
<td>14</td>
</tr>
<tr>
<td>15 Particle Accelerator</td>
<td>15</td>
</tr>
<tr>
<td>16 Cabinet X-ray</td>
<td>16</td>
</tr>
<tr>
<td>17 Open Beam X-ray</td>
<td>17</td>
</tr>
<tr>
<td>18 _________________ Other</td>
<td>18</td>
</tr>
<tr>
<td>19 Bone Densitometer</td>
<td>19</td>
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</tbody>
</table>

E. Please check one in each category:

1. Practice

2. Facility Category

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<th>Practice Type</th>
<th>Facility Category</th>
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</thead>
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<tr>
<td>2 Dental</td>
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<td>3 Chiropractic</td>
<td>3 Chiropractic</td>
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<tr>
<td>4 Osteopathy</td>
<td>4 Osteopathy</td>
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<td>6 Podiatry</td>
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<td>7 Industrial</td>
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<td>8 Research</td>
<td>8 Research</td>
</tr>
<tr>
<td>9 Institution</td>
<td>9 Institution</td>
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<tr>
<td>10 Other (Specify)</td>
<td>10 Other (Specify)</td>
</tr>
<tr>
<td>1 Private Office</td>
<td>1 Private Office</td>
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<tr>
<td>2 Hospital</td>
<td>2 Hospital</td>
</tr>
<tr>
<td>3 Clinic</td>
<td>3 Clinic</td>
</tr>
<tr>
<td>4 Mobile (see F below)</td>
<td>4 Mobile (see F below)</td>
</tr>
<tr>
<td>5 Education</td>
<td>5 Education</td>
</tr>
<tr>
<td>6 Industrial</td>
<td>6 Industrial</td>
</tr>
<tr>
<td>7 Institutional</td>
<td>7 Institutional</td>
</tr>
<tr>
<td>8 Specify</td>
<td>8 Specify</td>
</tr>
</tbody>
</table>

F. Van or Trailer I.D. No: __________________________ License Tag No. _________________________ Year: _______________ State: ___

G. List all x-ray machines at the facility or in mobile van (Use additional sheets if necessary)

Console Brand Name ____________________ Model No.________________________ Serial No. __________________________

H. Install x-ray systems that have been disposed of during the last report period: Console Brand Name ______________________________

Disposition__________________________ If sold, name ________________________________________________

I. For diagnostic Facilities except hospitals; List all practitioners who have the authority to prescribe x-rays. Please Print.

J. Only the person responsible for radiation safety may sign (i.e. the doctor in charge or RSO)

Authorized Signature/Title ____________________________

Print or Type Name ____________________________

Date: __________________________________________
# DIAGNOSTIC SERVICES UNIT

## APPLICATION FOR REGISTRATION OF LASER FACILITY

**CONTACT PERSON:** ____________________________________________  **PHONE:** ____________________

**NAME OF FACILITY:** __________________________________________________________________________

**ADDRESS OF FACILITY:** __________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Type of Use</th>
<th>A. Alignment</th>
<th>B. Communication</th>
<th>C. Copying</th>
<th>D. Demonstration</th>
<th>E. Experimental</th>
<th>F. Forensic</th>
<th>G. Instructional</th>
<th>H. Healing Arts</th>
<th>I. Readers</th>
<th>J. Research</th>
<th>K. Other</th>
</tr>
</thead>
</table>

**System Information:**

<table>
<thead>
<tr>
<th>Laser or Laser Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand</td>
</tr>
<tr>
<td>Lasing Medium</td>
</tr>
<tr>
<td>Pulsed</td>
</tr>
<tr>
<td>Scanning</td>
</tr>
</tbody>
</table>

**Maximum Power Output** ____________________  **W or J**

**Brief Description of Use:**

---

**Authorization Signature / Title**  
(Print or Type)  
Date

---

Equal Opportunity Employer

Revised 3/17/2010
INSTRUCTIONS FOR COMPLETING SHIELDING DESIGN SPECIFICATIONS

Before Starting Form Look At Sample Drawing:

(1.) Prepare a scale drawing of your x-ray suite. Be sure to indicate locations of all doors and windows, operator’s area, and darkroom, including film storage.

(2.) Label all barriers alphabetically starting in the upper left corner of the room.

(3.) Indicate use of adjacent area outside each barrier.

(4.) The travel and traverse limits of the x-ray tube should be indicated, if applicable. Travel is defined as the long dimension of movement and traverse as the short dimension. Be sure to show travel and traverse on your drawing.

Completing the Shielding Design Specification Forms:

(1.) Complete applicant and facility information on top portion of form. Use one form for each room or x-ray machine. Include mailing address if different.

(2.) Indicate use of machine. This would be the type of examination or treatment performed using the machine.

(3.) Design workload. State either the milliamp-minutes per week at 100 kVp or estimate the number of exposures that will be made during an average one week period.

(4.) Indicate maximum exposure time, kVp setting, and maximum milliamp setting anticipated under usual operating techniques.

(5.) Column 1. Barrier Designation: Fill in the barrier designations from your scale drawing.

(6.) Column 2. Distance from X-ray tube to barrier.

(7.) Column 3. Primary or Secondary barrier.

Indicate whether the barrier is a primary or secondary radiation barrier. A primary barrier is defined as a barrier toward which the x-ray beam could be directed. All other barriers are secondary barriers.
(8.) Column 4. Identify use of adjacent area outside this barrier.

(9.) Column 5. Controlled or Non-controlled Area.

The areas outside the x-ray room are either controlled access areas or non-controlled access areas. A controlled area is a defined area in which the exposure of persons to radiation is under the supervision of a Radiation Protection Supervisor. This implies that the controlled area is one that requires control of access, occupancy, and working conditions for radiation protection purposes.

Areas which are not part of the Radiology Department or suite should not be declared controlled for the purpose of permitting reduction in degree of protection of occupants. Areas within the Department or suite which are not directly related to the use of radiation sources should not be declared controlled areas.

Any space not meeting the definition of a controlled area is a non-controlled area.

(10.) Column 6. Construction Material and Thickness.

In order for Department staff to evaluate your shielding design, the construction materials and thicknesses of these materials at each barrier must be known. Be sure to include windows and doors.

As an example - for wall AB in our sample x-ray room there are two sheets of dry wall, each 2 inches thick. (Do not include studs and space between.)

In another example, the floor area which is located over a storage room is 2.5 inches of 147 pound concrete.

The addition of lead or other materials to reduce radiation exposure below regulatory requirements is to be indicated here. The amount of lead or lead equivalent material required can be calculated by using NCRP report 147.
Sample Medical
**SHIELDING DESIGN SPECIFICATION FORM**

**APPLICANT** _____________________________  **FACILITY NAME:** _____________________________

**ADDRESS** ______________________________

**MAILING ADDRESS (IF DIFFERENT)**

______________________________

______________________________

**COUNTY** ___________________________

**TELEPHONE** _________________________

**ROOM #** ___________________________

**USE OF MACHINE**

**DESIGN WORKLOAD**

**MAXIMUM kVp SETTING**

**IN MILLIAMPS MIN/WEEK**

**NORMAL USE**

**OR**

**MAXIMUM NUMBER FILMS/WEEK**

**MAXIMUM MILLIAMPS SETTING**

**ANTICIPATED** ________________________

**NORMAL USE**

**MAXIMUM EXPOSURE TIME**

**PROJECTED OPENING DATE** ____________

<table>
<thead>
<tr>
<th>BARRIER DESIGNATION</th>
<th>DISTANCE FROM X-RAY TUBE TO BARRIER</th>
<th>PRIMARY OR SECONDARY BARRIER</th>
<th>IDENTIFY USE OF ADJACENT AREA OUTSIDE THIS BARRIER</th>
<th>CONTROLLED OR NONCONTROLLED AREA</th>
<th>CONSTRUCTION MATERIAL AND THICKNESS</th>
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<td>CEILING</td>
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<tr>
<td>FLOOR</td>
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<tr>
<td>OPERATION BARRIER</td>
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<tr>
<td>WALL</td>
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<td>WALL</td>
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</table>

**REVISED 1/97**
LIST OF QUALIFIED INDIVIDUALS AND HEALTH PHYSICISTS

This is an incomplete list.
Also check community colleges and x-ray suppliers and repair engineers.
The Healthcare Facility Regulation Division does not recommend or support any individual, company or organization.

Keep all documentation of training.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Waldron, MS</td>
<td>2758 Terrell Trace Drive</td>
<td>770-952-3053</td>
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</tr>
<tr>
<td></td>
<td>Marietta, GA 30067</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home / Fax</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cell: 678-773-2813</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill Ramsay</td>
<td>Medical X-Ray Imaging</td>
<td>770-918-7550</td>
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<tr>
<td></td>
<td>4875 Fowler Drive</td>
<td></td>
<td></td>
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<tr>
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<td>Cumming, GA 30041-8917</td>
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<td>Rose McTee</td>
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<td>Phoenix Technology</td>
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<td></td>
<td>555 Sun Valley Dr. E-3</td>
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<tr>
<td></td>
<td>Roswell, GA 30076</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>770-645-1440</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fax: 770-645-1441</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jerry Allison</td>
<td>706-799-5389</td>
<td></td>
</tr>
<tr>
<td></td>
<td>August, GA</td>
<td>706-736-7422</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daniel Staton, Ph, Certified Radiological Physicist</td>
<td>205-979-6999</td>
<td>205-612-8127</td>
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<tr>
<td></td>
<td>Phoenix Technology</td>
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<td></td>
<td>Fax: 770-645-1441</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Thomas G. Ruckdeschel, M.S.</td>
<td>770-751-9707</td>
<td>770-753-4305</td>
</tr>
<tr>
<td></td>
<td>President Certified Alliance Physics</td>
<td>502 Abbey Court</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiological Physicist</td>
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<tr>
<td></td>
<td>502 Abbey Court</td>
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<td>Alpharetta, GA 30044</td>
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<td>770-753-4305</td>
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<td></td>
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<tr>
<td></td>
<td>Kerry Maughon</td>
<td>678-227-1255</td>
<td></td>
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<tr>
<td></td>
<td>Imaging Physics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 545 Winder, GA 30680</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cell: 770-868-0607</td>
<td></td>
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<td></td>
<td>Fax: 770-868-0607</td>
<td></td>
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<tr>
<td></td>
<td>Interstate Health Physics Consulting</td>
<td>139 Hunters Ridge Drive</td>
<td>Lexington, SC 29072</td>
</tr>
<tr>
<td></td>
<td>Bruce Gossett</td>
<td>803-356-4245</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patrick Booton</td>
<td>222 Wiley Bottom Rd.</td>
<td>Savannah, GA 31411</td>
</tr>
<tr>
<td></td>
<td>912-350-8000</td>
<td>912-598-0919</td>
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<td></td>
<td>Fax: 912-598-0919</td>
<td></td>
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<tr>
<td></td>
<td>Ed Rocker</td>
<td>770-842-7016</td>
<td></td>
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<td></td>
<td>Access Diagnostic Physics</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cell: <a href="mailto:ed@accessphysics.com">ed@accessphysics.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scott Sheilds</td>
<td>678-778-1084</td>
<td></td>
</tr>
</tbody>
</table>

Updated 02/15/2010 11:48 AM
Depending on the type of X-ray machine, the following initial X-ray Inspection Form(s) should be completed by the qualified individual.
BONE DENSITOMETERS
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: __________________________ PHONE: __________________________

NAME OF FACILITY: ____________________________________________________________

ADDRESS OF FACILITY: _______________________________________________________

        (Street)                  (City)                                                                                     (State)                             (Zip Code)                                                (County)

REGISTRATION NUMBER: __________________________-

1. Have there been any changes in ownership? YES___ NO__ If yes, provide the date of change_______________________
   Who is the previous owner?____________________________________________________________________________

2. Can the x-ray operator(s) get three feet from the beam when at the controls? YES___ NO___

3. Do you have an area monitor for the full body? YES___ NO___

4. Do you have lead apron(s) available? YES___ NO___

5. Do the operator(s) have the 6 hours mandatory radiation safety training and documentation? YES___ NO___

6. Do you have a record of daily calibrations? YES___ NO___

7. Do you have an operator’s manual? YES___ NO___

8. (a) Was an initial inspection /survey done by a qualified individual? YES___ If yes, what date? __________NO__ N/A____
    (b) Does the facility have the qualified individual’s credentials on file? YES___ NO___

9. Is a copy of the qualified individual’s report enclosed with this questionnaire? YES___ NO___

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure
enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for
X-ray.

Signature and Title of the responsible person_______________________________________________________________________

Return this form to DCH – HFRD Diagnostic Services Unit

Equal Opportunity Employer

Revised 3/18/2010
DENTAL
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON:_________________________________  PHONE:___________________________

NAME OF FACILITY:_______________________________________________________________

ADDRESS OF FACILITY:_________________________________________________________________

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER:_____________________-_____________________

1. Have there been any changes in ownership? YES___ NO__ If yes, provide the date of change:___________________
   Who is the previous owner?_________________________________________________________________

2. Does the x-ray tube head maintain its position during radiographic exposure? YES___ NO___ N/A ____

3. Are the open ended shielded cones the appropriate length 4” for 50KVP and less, 7” for KVP’s greater than 50? YES__ NO__

4. Is the operator is able to stand a minimum of 6 feet from the useful beam or behind a protective barrier?  YES____ NO____

5. Is the operator able to view the patient during exposure? YES___ NO___

6. Are all the controls properly labeled? YES____ NO____

7. Are the chemicals changed within a two month period and a permanent record maintained?  YES___NO___ N/A___

8. Is the darkroom light tight?  YES___NO___

9. Does the darkroom have a safelight with correct wattage and filter bulb?  YES___NO___

10. Are film badges worn and a record maintained?  YES___ NO___

11. Is there a warning statement on the x-ray machine?  YES___NO___

12. (a) Was an initial inspection/survey done by a qualified individual?  YES____ If yes, what date?__________ NO__ N/A__
   (b) Does the facility have the qualified individual’s credentials on file? YES___NO___

13. Is a copy of the qualified individual’s credentials enclosed with this questionnaire?  YES___ NO___

14. (a) Does the x-ray operator(s) have the 6 hours of mandatory radiation safety training and documentation? YES___NO___
   (b) How many? ____________________________________

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_______________________________________________________________________

Return this form to DCH – HFRD Diagnostic Services Unit

Revised 3/10/2010 Equal Opportunity Employer
NON-MEDICAL
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: __________________________ PHONE: __________________________

NAME OF FACILITY: ____________________________________________________________

ADDRESS OF FACILITY: __________________________________________________________

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____________________________

1. Have there been any changes in ownership? YES___ NO___ If yes, provide the date of change: ____________________________
   Who is the previous owner? ___________________________________________________________________________________________

2. Is the radiation hazards area identified by warning signs? YES___ NO___

3. Are audible or visible signals in the vicinity of installations provided to warn of radiation? YES___ NO___

4. Do you have a copy of normal operating and emergency procedures? YES___ NO___

5. Does your x-ray machine have a key operated primary control switch that cannot be operated, if the key is removed? YES___ NO___

6. Does this area (open beam only) have caution signs posted? YES___ NO___

7. Does this facility (open beam only) have a cumulative direct reading device and film badges or equivalent provided for use by person(s) in this 5mR/hr area? YES___ NO___

8. Does this facility have the correct survey meter for quarterly safety checks? YES___ NO___

9. Does the x-ray machine have a warning light labeled x-ray on which lights only when the tube is activated and which will prevent activation of the tube if it is not in working order? YES___ NO___ N/A___

10. (a) Was an initial inspection/survey done by a qualified individual? YES___ If yes, what date? ____________ NO___ N/A___
    (b) Does the facility have the qualified individual’s credential on file? YES___ NO___

11. Is a copy of the qualified individual’s report enclosed with this questionnaire? YES___ NO___

12. Does the x-ray operator(s) have the 2 hour mandatory safety training and documentation? YES___ NO___

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person _______________________________________

Return this form to DCH – HFRD Diagnostic Services Unit

Equal Opportunity Employer

Revised 3/17/2010
RADIOGRAPHIC
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON:___________________________________________________________
PHONE:_______________________________________________________________

NAME OF FACILITY:__________________________________________________________

ADDRESS OF FACILITY:
(Street)
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER:________________________

1. Have there been any changes in ownership? YES___ NO__ If yes, provide the date of change: ___________________
   Who is the previous owner?_________________________________________________________________________

2. Is the operator prevented from leaving the protected area of the booth (bone densitometer)? YES___NO___

3. Is the darkroom light tight? YES___NO___

4. Does the safelight meet the film manufacturer’s requirements?:
   (a) Correct wattage YES___NO___
   (b) the filter YES___NO___

5. Is there a record of chemicals changed within a two month period and /or meets the manufacturer’s suggestions and a record
   maintained of change? YES___NO___ N/A___

6. Are film badges worn by operators and a record maintained of exposures? YES___NO___

7. (a) Does the operator(s) have the 6 hours of mandatory radiation safety training and documentation? YES___NO___
    (b) How many? ____________________________________

8. Is there a lead apron available? YES___NO___

9. Is the operator able to view the patient during exposure? YES___NO___

10. (a) Was an initial inspection/survey done by a qualified individual? YES___ If yes, what date? _________ NO___ N/A___
    (b) Does the facility have the qualified individual’s credentials on file? YES___NO___

11. Is a copy of the qualified individual’s credentials enclosed with this questionnaire? YES___ NO___

12. Is there a warning statement on the control panel? YES___NO___

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure
enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for
X-ray.

Signature and Title of the responsible person_______________________________________________________________________

Return this form to DCH – HFRD Diagnostic Services Unit

Equal Opportunity Employer

Revised 3/17/2010
VETERINARY
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: __________________________________ PHONE: ___________________________

NAME OF FACILITY: ________________________________________________________________

ADDRESS OF FACILITY: ______________________________________________________________

REGISTRATION NUMBER: _____________________________

1. Have there been any changes in ownership? YES___ NO___ If yes, provide the date of change: ___________________________

   Who is the previous owner? __________________________________________________________

2. Is the operator able to stand a minimum of 6 feet from the x-ray beam? YES___ NO___

3. Are there lead aprons and lead gloves available for all people in the room during radiographic exposure? YES___ NO___

4. Is the darkroom light tight? YES___ NO___

5. Are the chemicals changed within a two month period and a permanent record maintained of change? YES___ NO___

6. Is there a working safelight with the correct filter and wattage bulb? YES___ NO___

7. If hand processing, is there a thermometer and timer available? YES___ NO___ N/A ___

8. Does the operator(s) have the 6 hour mandatory radiation safety training and documentation? YES___ NO___

9. Are film badges worn and records maintained? YES___ NO___

10. Does the machine have a warning statement? YES___ NO___

11. (a) Was an initial inspection/survey done by a qualified individual? YES___ If yes, what date? ____________ NO___ N/A ___

   (b) Does the facility have the qualified individual’s credentials on file? YES___ NO___

12. Is a copy of the qualified individual’s report enclosed with this questionnaire? YES___ NO___

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person ___________________________________________

Return this form to DCH – HFRD Diagnostic Services Unit

Equal Opportunity Employer

Revised 3/17/2010
MAIL ALL STATE X-RAY APPLICATIONS TO:

Diagnostic Services Unit
Health Care Section
Healthcare Facility Regulation Division
Department Of Community Health
2 Peachtree Street, N.W.
Suite 31-447
Atlanta, GA 30303-3142

ATTN: X-RAY PROGRAM

Because faxed copies may not be clear and may distort your information we ask that all original paperwork be mailed to the above address.

After we have reviewed your application, if we request additional documentation, you may fax any additions/changes and or supporting documents to:

(404)657–5442

Contact Personnel:

Sheela E. Puthumana BS MT (ASCP)        Dinella Sears
Program Manager       Program Assistant
Phone: (404) 657-5447      Phone: (404) 657-5400
                              Fax: (404) 657-5442

Revised: 02/15/2010 11:54 AM
An evaluation of the diagnostic x-ray facilities at your office was made on the above date to determine if the facility and equipment are operating in compliance with the Radiation Control Act and the Department of Human Resources Rules and Regulations for X-Ray Chapter 290-5-22.

(Compliance Code Number, in the column below, indicates the status of that machine and this facility.)

<table>
<thead>
<tr>
<th>#1 Compliance</th>
<th>#2 Non-compliance</th>
<th>#3 Not Applicable</th>
<th>#4 Undetermined</th>
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<td>Fail (☐)</td>
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<tr>
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<td>N/A (☐)</td>
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<td>WARNING LABEL</td>
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<td>Fail (☐)</td>
<td>N/A (☐)</td>
</tr>
</tbody>
</table>

ADDITIONAL REQUIREMENTS FOR PORTABLE MACHINES

| SSD | Pass (☐) | Fail (☐) | Explain: | Source to skin distance shall be limited to not less than 30 cm (12 in.) .04(13) |
| APRON | Pass (☐) | Fail (☐) | Explain: | Lead apron of at least .25mm lead equivalents is required. .04(13) |
| FILM BADGE | Pass (☐) | Fail (☐) | Explain: | Personnel monitoring is required for operators. .04(13) |
| SWITCH | Pass (☐) | Fail (☐) | Explain: | A distance of 1.8m from tube, patient, and beam or an operator’s barrier is required. .04(13) |
| OTHER | Pass (☐) | Fail (☐) | | Explain: |

X-RAY MACHINE IDENTIFICATION

A.  
B.  

DISCUSSED WITH SIGNATURE

Provided by
Alliance Medical Physics  · 2500 Abbey Court  · Alpharetta, GA 30004 · 770.751.9707