State of Colorado
Department of Public Health & Environment

Application for Registration Facility/Radiation Machines

INSTRUCTIONS: This application must be printed in ink. Please provide all information requested on this form. This form and copies of this form must have original signatures and dates. Mail original or email copies with all attachments to the **Colorado Department of Public Health and Environment, HMWMD Radiation Control Program, X-Ray Certification - RM-B2, 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530.** Please retain a copy of this application form for your records. All registrations of radiation machines are issued in accordance with the requirements contained in the Colorado Department of Public Health and Environment, *Rules and Regulations Pertaining to Radiation Control*, 6 CCR 1007-1, Part 2. If additional information is required to complete this form, please call (303) 692-3448 or (888) 569-1831 toll-free (outside the 303 area code), or fax (303) 759-5355 Attention: X-Ray Certification Unit.

Below, complete all items of the application as appropriate.

Application Date: _____ **Facility Registration #:**_____ **Federal Tax I.D. Number** (E.I.N.)	**Application Category** (check one): _____**New Application** _____**Change of Address** _____**Information/Correction of registration information** _____**Other** (change of ownership)

Application Information:

Business Name: _____ **Phone** Number: ( )_____

Registrant Name**:** (licensed practitioner, legal owner)_____ **Colorado License #:**_____

Last Name: _____**First Name:**_____**Title:**_____

Radiation Safety Officer: (RSO) **Phone** Number: ( )_____

Last Name: _____**First Name:**_____**Title:**_____

Facility Location Address:_____

City:_____ State: _____Zip Code:_____

Facility Mailing Address: (If different from above)_____

City:_____ State: _____Zip Code:_____

FAX Phone Number: ( )_____

Email Address:_____

Facility Type (Check your facility type)

_____MD, DO, Clinic _____Podiatrist, DPM _____Veterinary, DVM _____Hospital _____Accelerator/Medical _____Mobile Services

_____Dental, DDS, DMD _____Chiropractor, DC _____Industrial X-Ray _____Non Human Use _____Accelerator/Industrial _____Other

Total Number of radiation machines registered: _____ Please check whether your facility is _____**Digital** _____**Computed Radiography**
(See attached pages)

I certify As owner/registrant, "I_____, the undersigned Owner/registrant, certify that: The information contained in this registration form is to the best of my knowledge, true, accurate and complete in all aspects; I have on file, a **Shielding Design & Analysis** for all machines, if applicable; a **list of current operators**, according to 6 CCR 1007-1, Part 2 and Part 6 of *the Rules and Regulations Pertaining to Radiation Control*; The applicant and any official executing this certificate on behalf of the applicant named in the application certify that this application is prepared in conformity with the Colorado Department of Public Health and Environment's Rules and Regulations pertaining to Radiation Control and that all information contained herein, including any attachments hereto, is true and correct to the best of our knowledge and belief.

_____
Owner/Registrant Date

Mail Original to:
Colorado Department of Public Health and Environment
HMWM-B2 X-Ray Certification
4300 Cherry Creek Drive South
Denver, CO 80246-1530

FOR XRP USE ONLY

Registration No._____

Registration Date:_____

Cross-Ref #:_____

-Certifying Official-

R-4a REGISTRATION OF RADIATION MACHINES PAGE _____ OF _____

REGISTRATION NUMBER: _____

X-Ray Machine Information

Machine TYPE [Indicate with an X in the appropriate square(s)]:

☐ General diagnostic radiographic ☐ General purpose fluoroscopic or combination radiographic/fluoroscopic ☐ Mammographic

☐ C-Arm fluoroscopic ☐ CT Head Scanner ☐ CT Whole Body Scanner ☐ Accelerator/Medical ☐ Bone Densitometry ☐ Volumetric Dental

☐ Dental Intraoral ☐ Dental Panoramic ☐ Dental Cephalometric ☐ Podiatry ☐ Veterinary/Radiographic ☐ Veterinary/Fluoroscopic ☐ Handheld Unit

☐ Mobile (describe): _____ ☐ Industrial radiographic machine ☐ Accelerator/Industrial ☐ Analytical ☐ Other (describe) _____

☐ Fixed Unit ☐ Portable ☐ Mobile Vehicle ☐ Other: _____

Control Location/Rm#:	Control Mfg:	Control Model:	Control s/n:	Control Date of Mfg.:
Tube Identification #:	Tube Mfg:	Tube Model:	Tube s/n:	Tube Date of Mfg.:
Date of Installation:	Blue Certification Label #:	Exp. Date on Blue Label:		
Misc. Comments:				

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Control Location/Rm#:	Control Mfg:	Control Model:	Control s/n:	Control Date of Mfg.:
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