

State of Rhode Island Department of Health

Application for Registration and Instructions for

Radiation Physics Services

RI General Laws Chapter 23-1.3

Registrant Name: _				
Registration Numb	er: RPS			
Reason for applica	tion (Please check all that apply):			
1. Initial Registra	ation			
2. Change of add	lress: What is your current registration nu	ımber:		
3. Change of ow	nership: What is your current registration	number:		
4. Registrant Na	ame Change:			
For Agency Use Only	Category: RPS Registration No.:	Conditions:		=
	Reviewed By:	Date:	Amount Paid:	
	Number of Active X-Ray Tubes: N/A	Number of X-Ray T	ubes in Storage: N/A	

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INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your registration will not be issued. If completing manually, please use a ball point pen.
- The fee for this registration application is \$150 made payable to: RI General Treasurer
- Sign the completed application and return to:

Radiation Control Program Center for Health Facilities Regulation Rhode Island Department of Health 3 Capitol Hill, Room 305 Providence, RI 02908-5097

- If you have any questions concerning this application, call the Radiation Control Program at (401) 222-2566.
- Registration application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Processing: For expedited processing of your registration, a valid email address must be provided wherever requested.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Name: Prefix (optional) First Name (Mr./Mrs./Ms./Dr.)	Last Name	Suffix (Jr/III)	
DD/MM/YYYY			
Male Female			
Address Line 2 (Number and Street) Address Line 3 Address City, State, Zip Code Address Country (if NOT USA) Home Phone: Fax:		Postal Code (if NOT USA)	
Address Line 1 ((Department/Suite/Room N Address Line 2 (Number and Street) Address Line 3 Address City, State, Zip Code Address Country (if NOT USA) Business Phone: Business Fax:	Number, etc.)	Postal Code (if NOT USA)	
	Male Female Address Line 1 (Apartment/Suite/Room Nu Address Line 2 (Number and Street)	Address Line 1 (Apartment/Suite/Room Number, etc.) Address Line 2 (Number and Street) Address Line 3 Address City, State, Zip Code Address Country (if NOT USA) Home Phone: Fax: Home Email Address [Format for email address is Username@domain (e. Name of Business: Address Line 1 ((Department/Suite/Room Number, etc.) Address Line 2 (Number and Street) Address Line 3 Address City, State, Zip Code Address Country (if NOT USA) Business Phone: Extension: Business Fax:	Address Line 1 (Apartment/Suite/Room Number, etc.) Address Line 2 (Number and Street) Address City, State, Zip Code Address Country (if NOT USA) Home Phone: Fax: Home Email Address [Format for email address is Username@domain (e.g. applicant@isp.com)]: Name of Business: Address Line 1 ((Department/Suite/Room Number, etc.) Address Line 2 (Number and Street) Address Line 3 Address City, State, Zip Code Address City, State, Zip Code Address Country (if NOT USA) Business Phone: Extension:

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Radiation Physics Services requested

Applicants must provide education/ experience meeting the requirements of §§ 3.6 and 3.14 of 216-RICR-40-20, *Radiation*.

Please check the applicable box(s) for the Radiation Physics services being requested and attach required supporting documentation (i.e. certificates, transcripts) to this application.

- 01 Calibration of health physics instrumentation
- 02 General radiation physics services to medical radioactive materials licensees
- 03 General radiation physics services to non-medical radioactive materials licensees
- 04 General radiation physics services to medical X-Ray facility registrants
- 05 General radiation physics services to non-medical X-Ray facility registrants
- 06 Calibration of diagnostic X-Ray equipment
- 07 Calibration of therapeutic medical devices utilizing sealed radioactive sources:
 - A. Teletherapy units
 - B. HDR Brachytherapy units
 - C. Stereotactic Radiosurgery units
- 08 Calibration of therapeutic radiation machines as defined in Part 5 of 216-RICR-40-20, Radiation
- Other specialized radiation physics services and/or surveys (please specify): _

Acknowledgements

I am aware of Chapter 23-1.3 of the General Laws of Rhode Island, 1978, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Agency shall, in conformity with the authority continued under Chapter 23-1.3 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

Social Security Number

Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any registration, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide SSN for this registration:

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed by the Applicant

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of this Registration in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature of Applicant

Date of Signature (MM/DD/YYYY

Printed Name of Applicant