



**RHODE ISLAND RADIATION CONTROL AGENCY  
APPLICATION FOR REGISTRATION OF  
A THERAPEUTIC RADIATION MACHINE FACILITY**

**Category**    **Lic. No.**     **Conditions** \_\_\_\_\_

**\*\*FOR AGENCY USE ONLY\*\***

**Reviewed By** \_\_\_\_\_

**Date** \_\_\_\_\_

**\$** \_\_\_\_\_

**Amount Paid**

INSTRUCTIONS: Subpart B.3 and H.3 of the *Rules and Regulations for the Control of Radiation [R23-1.3-RAD]* contains detailed instructions for completing this application. **Send the entire completed application to: RI Department of Health, Office of Facilities Regulation, Radiation Control Program, 3 Capitol Hill - Room 305, Providence, RI 02908-5097.** You should keep a copy of your completed application and attachments, as they will be incorporated into your registration by reference. Checks should be made payable to RI General Treasurer.

**THIS IS AN APPLICATION FOR** [*Check Appropriate Item*]  NEW REGISTRATION  
 AMENDMENT TO REGISTRATION # \_\_\_\_\_  CATEGORY CHANGE TO REGISTRATION \_\_\_\_\_

**Facility Name:**  
Please provide the name of the facility (as known to the public) for which you are applying for this license.

Name: \_\_\_\_\_

**Facility Contact Person:**  
Please provide the name and telephone number of a person we can contact concerning this facility.

Name: \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_

**Facility Mailing Information:**  
Please provide the mailing information for all communication regarding this license.  
  
(Not published on HEALTH website).

Address Line 1 \_\_\_\_\_  
Address Line 2 \_\_\_\_\_  
Address Line 3 \_\_\_\_\_  
Address City, State, ZipCode \_\_\_\_\_  
Address Country \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Facility Location Information:**  
Please provide the location information for this facility.  
  
(Published on HEALTH website).

Address Line 1 \_\_\_\_\_  
Address Line 2 \_\_\_\_\_  
Address Line 3 \_\_\_\_\_  
Address City, State, ZipCode \_\_\_\_\_  
Address Country \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Facility Supervisor Information:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
RI Medical License Number: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Medical Certification(s): \_\_\_\_\_ Date(s): \_\_\_\_\_

**Individual Responsible for Radiation Protection:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Title: \_\_\_\_\_

