



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

Category ☐☐☐ Lic. No. ☐☐☐☐ ****FOR AGENCY USE ONLY****
Conditions _____

/ / S

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: _____

Radiotherapy Physicist: RI Registration Number: RPS- _____	Name: _____ Phone Number: _____ Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Street City State Zip Code </div>												
Ownership Type: Please check ONE	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Corporation</div> <div style="width: 50%;"><input type="checkbox"/> Limited Liability Company</div> <div style="width: 50%;"><input type="checkbox"/> Governmental Entity</div> <div style="width: 50%;"><input type="checkbox"/> Partner</div> <div style="width: 50%;"><input type="checkbox"/> Sole Proprietorship</div> <div style="width: 50%;"><input type="checkbox"/> Partnership</div> <div style="width: 50%;"><input type="checkbox"/> Limited Partnership</div> </div>												
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____												
INTENDED USE OF THERAPEUTIC RADIATION MACHINE(S): [Check ALL Applicable Items] <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> 5-50 kV System(s) [H.6]</div> <div style="width: 50%;"><input type="checkbox"/> Photon Therapy System(s) (500 kV & above) [H.7]</div> <div style="width: 50%;"><input type="checkbox"/> >50 and <500 kV System(s) [H.6]</div> <div style="width: 50%;"><input type="checkbox"/> Electron Therapy System(s) (500 keV & above) [H.7]</div> </div>													
THERAPEUTIC RADIATION MACHINE INFORMATION: Provide the requested information for each therapeutic radiation machine(s) owned or possessed by the facility.													
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 15%;">Unit #*</th> <th style="width: 25%;">Manufacturer</th> <th style="width: 20%;">Model</th> <th style="width: 20%;">Energy</th> <th style="width: 15%;">Type</th> <th style="width: 15%;">Location</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Unit #*	Manufacturer	Model	Energy	Type	Location						
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<p><small>*Therapeutic radiation machines also require submission of a shielding evaluation and documentation of compliance with Subpart H.9 of the <u>Rules and Regulations for the Control of Radiation [R23-1.3-RAD]</u> for each location/unit. [Continue on plain 8½" by 11" paper if necessary.]</small></p>													
OPERATING PERSONNEL: Identify all individuals who will be authorized to operate the therapeutic radiation machine(s). Provide documentation of compliance with Section H.3.5 of the <u>Rules and Regulations for the Control of Radiation [R23-1.3-RAD]</u> for each individual.													
DOSIMETRY SERVICE PROVIDER: Identify the dosimetry service to be utilized at the facility.													
DOSIMETRY EQUIPMENT: Identify the dosimetry equipment that will be used to demonstrate compliance with Section H.4.3 of the Rules and Regulations for the Control of Radiation [R23-1.3-RAD].													
FEIN Number: (Federal Employer Identification Number) Note: If you are a sole proprietor this number may be your Social Security Number.	Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, 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 below FEIN/SSN for this license: F.E.I.N./SSN Number: _____												
CERTIFICATION [Must be completed by applicant]: The applicant and any official executing this certification on behalf of the applicant, certify that this application is prepared in conformity with the <u>Rhode Island Rules and Regulations for the Control of Radiation [R23-1.3-RAD]</u> , and that all information contained herein is correct to the best of their knowledge and belief.													
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> _____ (Signature) </div> <div style="width: 45%;"> _____ (Type or Print Name of Certifying Official) </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> _____ Date </div> <div style="width: 45%;"> _____ Title: </div> </div>													
FACILITY SUPERVISOR: _____ [If different from Certifying Official]: _____ (Signature) _____ (Date)													