

# Ohio Department of Health • Bureau of Radiation Protection

## APPLICATION for Registration of Radiation-Generating Equipment

Electronically submitted applications can be processed within 2–3 business days at  
<http://www.odh.ohio.gov/odhPrograms/rp/registration/app.aspx>

FOR REGISTRATION STAFF USE ONLY

- IRS 147C letter attached
- Check or money order attached

If unable to apply electronically at the web address above, the following three items must be submitted;

- a signed, completed three-page Application (form HEA5104 12/10)
- an IRS 147C Tax Identification Verification letter and
- a non-refundable check or money order for the amount of two hundred sixty two dollars (\$262.00) shall be made payable and sent to:

**Treasurer, State of Ohio, Ohio Department of Health,  
 Attn: Revenue Processing Section, P0 Box 15278, Columbus, OH 43215-0278**

If you have questions or need assistance in completing this form, call 614.644.2727, option 2, X-ray Registration.

At least **30 days prior to handling the equipment**, submit a completed application and a non-refundable required payment. Each separate address location with Radiation Generation Equipment (RGE) must submit a completed application.

If adding additional equipment to a current registration, then submit an amendment, no fees due. A new application is not required for an address already registered with ODH.

Registrations are not transferrable. If this is an ownership change, the new owner must submit a new application with \$262.00 fee. A Transfer or Disposal form HEA5508 is required to terminate the previous owner's record.

### IRS 147C Tax Identification Verification Letter

To obtain your 147C letter, call IRS at 1-800-829-0115 and request your "Tax Identification Verification 147C Letter" and have the IRS FAX or e-mail the letter to you. This process will take 5-10 minutes (NO FORM OTHER THAN THE 147C LETTER WILL BE ACCEPTED.)

PLEASE TYPE OR PRINT CLEARLY

**Registrant or Facility name**—*The official name on the 147C letter is the "Registrant name" to be entered on the application.*

Registrant name *(Must match Federal Tax ID on record with IRS)*

### Applicant category *Select only one*

- |   |  |   |   |
|---|--|---|---|
| 1. <input type="checkbox"/> Chiropractic Office | 6. <input type="checkbox"/> Mobile Health Care Serv. | 11. <input type="checkbox"/> Government Agency          | 16. <input type="checkbox"/> Correctional Facility  |
| 2. <input type="checkbox"/> Dental Office       | 7. <input type="checkbox"/> Registered Hospital      | 12. <input type="checkbox"/> Assembler / Maintainer     | 17. <input type="checkbox"/> Public Utility         |
| 3. <input type="checkbox"/> Physicians Office   | 8. <input type="checkbox"/> Non-Registered Hospital  | 13. <input type="checkbox"/> Corporate Office           | 18. <input type="checkbox"/> Engineer / Contractor  |
| 4. <input type="checkbox"/> Podiatry Office     | 9. <input type="checkbox"/> Educational Institution  | 14. <input type="checkbox"/> Manufacturer               | 19. <input type="checkbox"/> Transportation Company |
| 5. <input type="checkbox"/> Veterinary Office   | 10. <input type="checkbox"/> Clinic / Imaging Center | 15. <input type="checkbox"/> Laboratory / Testing / R&D | 20. <input type="checkbox"/> Other _____            |

**Federal Tax ID number**—*The Tax ID# on the 147C letter is the tax number to be entered on the application.*

*(If no federal tax ID number, contact Bureau. **DO NOT** use social security number).*

Federal Tax ID (FTI) <i>Must be included</i>	SSN (only if no FTI is available)

# APPLICATION for Registration of Radiation-Generating Equipment

## Individual Responsible for Radiation Protection

Name	Email
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## Address

### Mailing address *Letter and Certificates*

Phone (       )	Ext	Fax (       )	
<b>Mailing name or DBA name</b>			
Street address			
City	State	ZIP	County

### Billing address *Invoices*

Same as mailing address <input type="checkbox"/>	Phone (       )	Ext	Fax (       )
<b>Billing name or DBA name</b>			
Street address			
City	State	ZIP	County

### X-Ray source location *Current address where radiation-generating equipment is located*

Same as mailing address <input type="checkbox"/>	Phone (       )	Ext	Fax (       )	
<b>Source location name or DBA name</b>				
Street address				
Same as billing address <input type="checkbox"/>	City	State	ZIP	County

### Additional information *(optional)*

Please note the requirements of Ohio Administrative Code 3701:01-38-01(C) Every facility that proposes to handle radiation-generating equipment for which registration is required shall apply for a registration at least thirty days prior to handling the equipment. Registration or renewal thereof shall be in accordance with this rule; and Ohio Administrative Code 3701:01-38-01 (G) Registrations shall be renewed in accordance with the standard renewal procedure established in Chapter 4745. of the Ohio Revised Code. The registrant shall apply for renewal at least thirty days prior to the expiration of the registration every two years thereafter.

# APPLICATION for Registration of Radiation-Generating Equipment

## Radiation Sources (x-ray tubes)

If a machine has more than one x-ray tube, list the components separately.

	Number Operable	Number Inoperable		Number Operable	Number Inoperable
<b>Medical</b>			<b>Veterinary</b>		
M1 Radiographic (Stationary)	( )	( )	V1 Radiographic (Stationary)	( )	( )
M2 Radiographic (Mobile)	( )	( )	V2 Dental	( )	( )
M3 Bone Densitometry	( )	( )	V3 C.T. (Computerized Tomography)	( )	( )
M4 C.T. (Computerized Tomography)	( )	( )	V4 Fluoroscopic	( )	( )
M5 Mammography	( )	( )	V5 Therapy Operates at 1 MV and above (Linear Accelerator)	( )	( )
M6 Stereotactic Biopsy	( )	( )	V6 Radiographic (Mobile)	( )	( )
M7 Fluoroscopic: Under Table	( )	( )	<b>Non-Medical – Analytical</b>		
M8 Fluoroscopic: Above Table	( )	( )	R1 Gauging	( )	( )
M9 Fluoroscopic: C-Arm (Stationary)	( )	( )	R2 Electron Microscope/ Photoelectronic Spectrometer	( )	( )
M10 Fluoroscopic: C-Arm (Mobile)	( )	( )	R3 Open Beam Analytical	( )	( )
M11 Fluoroscopic: C-Arm (Miniature)	( )	( )	R4 Closed Beam Analytical (Examples: Diffraction, fluorescence spectrometer, auger microprobe, luminescope, particle analyzer)	( )	( )
M12 Fluoroscopic: Lateral	( )	( )	R5 Hand-held Analytical	( )	( )
<b>Dental</b>			<b>Non-Medical – Radiography and Irradiation Devices</b>		
D1 Intraoral	( )	( )	S1 Particle Accelerator	( )	( )
D2 Panorol	( )	( )	S2 Bomb Detector	( )	( )
D3 Extraoral other than Panorol	( )	( )	S3 Enclosed System designed to <b>exclude</b> admittance of individual or their extremities. ( ) ( ) (Examples: Baggage, cabinet fluoroscopic, cabinet irradiation, cabinet radiographic-fluoroscopic, cabinet ion beam device)		
D4 Extraoral with Intraoral	( )	( )	S4 Enclosed System designed to <b>allow</b> admittance of individual ( ) ( ) (Examples: Radiographic, CT, fluoroscopic, tomography)		
D5 Extraoral with Panorol	( )	( )	S5 Radiographic ( ) ( ) (Examples: Non-enclosed unit or temporary job site)		
D6 Dental CT	( )	( )	S6 C-Arm Miniature ( ) ( )		
D7 Hand-held Dental	( )	( )	<b>Miscellaneous</b>		
<b>Therapy</b>			E70 Tube Only ( )		
T1 Operates below 250 kVp	( )	( )			
T2 Operates at or above 250 kVp and less than 1 MV	( )	( )			
T3 Operates at 1 MV and above (Linear Accelerator)	( )	( )			
T4 Simulator: C.T.	( )	( )			
T5 Simulator: Radiographic	( )	( )			
T6 Simulator: Fluoroscopic	( )	( )			

Equipment or Tube(s) rendered inoperable or in storage must be registered.  
Inspections are conducted on inoperable equipment at no charge.

**Signature** (If an organization, signature of responsible officer) *Signature and date required for processing*

Signature		Date (mm/dd/yy)	
Printed Name	Title		

Completion of this form is required by Ohio Revised Code Section 3748.06 (Failure to apply may result in civil or criminal penalties).

## HOSPITAL CATEGORY "07" ONLY

**Identification of Hospital Certified Radiation Experts (CRE)** (List one name per category and complete all categories).

Registered hospitals are required to complete the information below.

### Diagnostic CRE *other than mammography*

Last name	First name	MI	CRE#	Expiration date

### Mammography CRE

Last name	First name	MI	CRE#	Expiration date

### Therapeutic CRE

Last name	First name	MI	CRE#	Expiration date