DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

2401 Colonial Drive
PO Box 202953
Helena, MT 59620-2953
www.dphhs.mt.gov

RADIATION MACHINE REGISTRATION

Montana rules pertaining to Radiation Control require registration of all radiation machines.

Date: ____________________________

Facility/Owner Name: ____

Address: ____

City: _______________________ State: __________ Zip Code: _______________________

County: ____________________ Telephone: (____) __________ Fax: (____) __________

Type of Facility	Type of Practice		Work-load
□ Hospital	□ Dental	□ Analytical	Number of exams per month ______
□ Clinic	□ Physician	□ Veterinarian	
□ Private Office	□ Podiatry	□ Industrial	
□ Other	□ Other	□ Chiropractic	

REGISTRATION DOES NOT IMPLY APPROVAL OR DISAPPROVAL OF INSTALLATION

Please mail the completed original form to Montana Department of Public Health and Human Services, Quality Assurance Division, Licensure Bureau, Radiological Health Program, P. O. Box 202953, Helena, MT 59620-2953. A duplicate copy should be retained in your records. If you have questions, please call (406) 444-2676.

Name and Position of person filing application: Name: ________________________________

Signature: ______________________________

Name of Radiation Protection Officer: ____

Position: ____

If any of the registered machines from page 2 were used machines acquired from a private party or institution within the last two years, please indicate the machine, state the name and address of its previous owner, and the month and year of acquisition. ____________________________

____

____

If you have traded or sold an x-ray machine to private party or institution within the last two years, please state the make and model of the machine, the month of transaction, and the name and address of the party who received the machine. ______________________________________

____

____

Radiographic Machine Registration

Machine	Machine Manufacturer	Control Model	Master Control	Serial Number	Class	Fixed or Mobile	Max kVp	Max mA(s)	Number of Tubes
1			□ New □ Existing (Certified) □ Existing Noncertified)						
2			□ New □ Existing (Certified) □ Existing (Noncertified						
3			□ New □ Existing (Certified) □ Existing (Noncertified						
4			□ New □ Existing (Certified) □ Existing (Noncertified						
5			□ New □ Existing (Certified) □ Existing (Noncertified						
6			□ New □ Existing (Certified) □ Existing (Noncertified						
7			□ New □ Existing (Certified) □ Existing (Noncertified						
8			□ New □ Existing (Certified) □ Existing (Noncertified						
9			□ New □ Existing (Certified) □ Existing (Noncertified						
10			□ New □ Existing (Certified) □ Existing (Noncertified						

Use the Following Classifications:

(A) Radiographic
(B) Fluoroscopic
(C) Therapy

(D) Industrial
(E) Analytical
(F) Dental

(G) R/F Unit
(H) Mammography
(I) CT

If any of the above listed were used machines acquired from a private party or institution within the last two years, please indicate the machine, state the name and address of its previous owner, and the month and year of acquisition on the lines supplied on page 1 of this form.