



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

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

Date: \_\_\_\_\_

Facility/Owner Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

<u>Type of Facility</u>	<u>Type of Practice</u>	<u>Work-load</u>
<input type="checkbox"/> Hospital	<input type="checkbox"/> Dental	Number of exams per month _____
<input type="checkbox"/> Clinic	<input type="checkbox"/> Physician	
<input type="checkbox"/> Private Office	<input type="checkbox"/> Podiatry	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	
	<input type="checkbox"/> Analytical	
	<input type="checkbox"/> Veterinarian	
	<input type="checkbox"/> Industrial	
	<input type="checkbox"/> 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			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing Noncertified)						
2			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
3			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
4			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
5			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
6			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
7			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
8			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
9			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> Existing (Noncertified)						
10			<input type="checkbox"/> New <input type="checkbox"/> Existing (Certified) <input type="checkbox"/> 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.