July, 2009

South Dakota
State Health Department
Licensure and Certification Program

Application for License of Radiation Machine (Ionizing)

(See Instructions on Reverse Side)

For Office Use Only

License No.
Date Licensed
Expiration Date

☐ New License ☐ Renewal License ☐ Change of Address or Other Information

Facility Information

1. Name of Owner: (Individual, Hospital, Corporation, etc.) | 2. Area Code – Telephone No.

3. Mailing Address: No. and Street | City and State | Zip Code

4. Address at which Machine will be used, if Different from Above
☐ Same as Item 3 | 5. Dept. or room at which Machine will be used

6. Type of Facility
01 ☐ Hospital 02 ☐ Medical Clinic 03 ☐ Private Medical Practice 04 ☐ Educational Institution
07 ☐ Private Dental Practice 08 ☐ Other (Specify)

User Information

7. Individual in Charge of Machine
☐ Same as Item 1

8. Individual Responsible for Radiation Protection
☐ Same as Item 7

9. Classification of Individual in Charge of Machine
01 ☐ Dentist 02 ☐ General Practitioner 03 ☐ Dental Hygienist 04 ☐ Registered X-Ray Tech.
05 ☐ Radiologist 07 ☐ Veterinarian 08 ☐ Non-Registered X-Ray Tech. 09 ☐ Dental Assistant
10 ☐ Podiatrist 11 ☐ Chiropractor 12 ☐ Other

10. Facility Contact
☐ Same as Item 7

11. Equipment Installer

Machine Information

12. Machine Description

A. Medical X-Ray
01 ☐ Fluoroscopic w/Image Intensifier
02 ☐ General Radiographic
03 ☐ Photofluorographic/cine, etc.
04 ☐ Mammographic
05 ☐ Tomographic
06 ☐ Digital Imaging
07 ☐ Therapy
08 ☐ CT Scanner
09 ☐ Special Procedures
10 ☐ C-ARM

B. Dental X-Ray
11 ☐ Conventional
12 ☐ Panoramic
13 ☐ Cephalometric

C. Radiation Therapy
14 ☐ Accelerator
15 ☐ Simulator

D. Other X-Ray
16 ☐ Bone Densitometer
17 ☐ Other (Specify):

13. Machine is:
1 ☐ Fixed
2 ☐ Mobile
3 ☐ Portable

		14. Manufacturer	B. Model No.	C. Serial No.	D. Max. KVP	E. Max. MA
Control Panel * (as applicable)						
	1.					
	2					
	3					
	4					

15. Do you possess:

Licensed radioactive material ☐ Yes ☐ No NRC License No.

16. This is to certify that to the best of my knowledge and belief all information contained herein, including any supplements attached hereto is true and correct.

Date	Applicant Named in Item 1	By	Title

17. **Include a check payable to the State of South Dakota for:** ☐ 1 Unit = $100.00 ☐ 2 to 5 Units = $150.00
☐ 6 to 10 Units = $200.00 ☐ 11 to 20 Units = $250.00 ☐ 21 or More Units = $300.00

Note: All applications must be signed and dated.

This form may be copied if additional forms are needed.

Submit completed original to:
South Dakota Health Department
Licensure and Certification Program
615 East 4th Street
Pierre, South Dakota 57501-1700

***** Please List Additional Equipment On A Separate Sheet Of Paper.

Instructions for Completing License Application Form

Indicate whether the application is for new registration, a renewal of previous registration, or for change of address, ownership or other information.

1. Item 1 refer to the legal title and/or administrative control of the radiation machine.

2. Item 2 is self-explanatory.

3. When giving mailing address, be sure to include zip code.

4. List address(es) at which machine may be used other than the address listed in Item 3. If statewide, countywide, citywide, or offshore, please designate. If the same as item 3 please check the box provided.

5. Please give the department or room number where the radiation machine will be primarily used or store, if applicable.

6. Please classify the facility according to its primary usage.

7. Item 7 refers to that person specifically designated in charge of the radiation machine that is being registered. If the same as Item 1, please check box provided.

8. List the individual to whom is delegated responsibility for radiation control for the facility. If the same as Item 7, please check the box.

9. Item 9 is the classification of the individual who is listed in Item 7. Please check the appropriate box.

10. List the facility contact for scheduling surveys. If same as item 7 check box.

11. List the company in charge of installing the equipment.

12. By checking the appropriate box, please indicate the type of radiation machine that is to be registered. If the radiation machine does not fit one of the categories listed, please specify the type opposite box 17.

13. Indicate by check whether the machine is fixed, mobile, or in-house portable.

14. Please identify the radiation machine by indicating the:

    a. Manufacturer's name of control panel and tubeheads;

    b. Model number of control panel and tubehead(s) (where number is accessible to the applicant);

    c. Serial number of control panel and tubehead(s) (where number is accessible to the applicant);

    d. Maximum kilovoltage unit may be operated;

    e. Maximum milliamperage unit may be operated.

15. Please check the appropriate box.

16. Please execute the certification required by Item 14. Where the applicant is a hospital, corporation, educational institution, etc., that name should appear in the top blank, and the person responsible for the unit should sign below, giving his title.

17. **Include a check payable to the state of South Dakota.**

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