DHR

B. J. Walker, Commissioner

GEORGIA DEPARTMENT OF HUMAN RESOURCES • OFFICE OF REGULATORY SERVICES • HEALTH CARE SECTION
TWO PEACHTREE STREET NW • SUITE 33-250 • ATLANTA GEORGIA 30303-3142 • (404) 657-5400 • FAX (404) 657-5442

INSTRUCTIONS FOR X-RAY REGISTRATION

In accordance with the Radiation Control Act, Chapter 31-13 of the **Official Code of Georgia Annotated**, and the **Rules and Regulations for X-Ray, Chapter 290-5-22,** users of radiation machines are required to be registered with the Department **prior to the operation** of X-ray equipment in Georgia. An approved registration requires submission of a registration application, an approved shielding design, and an initial inspection.

The Department will acknowledge receipt of all relevant materials. Disapproved shielding designs will be returned for modification. Facility registration is not transferable, however an approved shielding design for a specified facility may be used by a subsequent owner for registration purposes, provided x-ray use is within specified conditions. **Relocations** require a new application, shielding design and an initial inspection.

Be advised that: **A FACILITY MAY NOT OPERATE X-RAY MACHINES UNTIL AN INITIAL INSPECTION IS DONE. FAILURE TO REGISTER YOUR MACHINES IN ACCORDANCE WITH REGULATIONS WILL CAUSE YOU TO BE SUBJECT TO CIVIL MONEY PENALTIES NOT TO EXCEED $1,000.00 OR DENIAL OF REGISTRATION OR BOTH.** Due to a backlog of inspections, the X-ray Unit is approximately six weeks behind in completing initial inspections. If you wish to operate the X-ray equipment sooner, you may opt to have an individual qualified at § § 290-5-22-.02(1)(d) and .02(4) to perform the initial inspection at your own expense.

Enclosed is a package of information that contains forms and materials that you are required to submit to this Office within (30) days. The materials included are:

___ 1. **Rules and Regulations for X-Rays** www.ors.dhr.georgia.gov
Click on **SERVICES** Click on **PRIMARY HEALTH CARE** Scroll down Click on **X-RAY FACILITIES** Scroll down **to Rules and Regs.**
___ 2. Shielding Design Format Requirements with example
___ 3. Reportable Incidents Instruction
___ 4. Initial Inspection Form

Any questions concerning the requirements in this letter may be addressed by calling 404-657-5400. To aid you in completing the forms, directions are enclosed in your packet.

GEORGIA DEPARTMENT OF HUMAN RESOURCES • DIAGNOSTIC SERVICES UNIT
2 PEACHTREE STREET, NW, 33RD FLOOR
ATLANTA, GEORGIA 30303-3142 • (404) 657-5400 • FAX (404) 657-5442

APPLICATION FOR X-RAY REGISTRATION

A. Applicant: _____ Facility _____
(Please Print or Type)

Facility Address: _____ Mailing Address: _____

_____

County: _____ Telephone ( ) _____ Fax ( ) _____

B. Has a Radiation Shielding Design for this facility been submitted to the X-ray Unit for approval: A plan must be submitted as part of the initial registration requirements: [ ] Yes [ ] No If yes, plan review no. _____

C. Is This Application for: (check all that apply)

[ ] A new Facility
[ ] A purchase of new equipment
[ ] Relocation
[ ] Update information of previously registered
[ ] Other _____

Have you previously registered an X-ray Facility in Georgia? [ ] Yes [ ] No
If yes, under what name: _____
_____
And in what county: _____

D. Equipment type: (Indicate the number of machines in each category):

____ 1 Dental Intraoral
____ 2 Dental Cephalometric
____ 3 Dental Panographic
____ 4 Radiographic Only
____ 5 Fluoroscopic Only
____ 6 R & F Same Unit No of tubes ____
____ 7 Mammography
____ 8 C-Arm
____ 9 Computerized Tomography
____ 10 Photofluorographic
____ 11 Analytical X-ray
____ 12 Particle Analyzer
____ 13 Therapeutic (less than 0.9 Mev)
____ 14 Therapeutic Accelerator
____ 15 Particle Accelerator
____ 16 Cabinet X-ray
____ 17 Open Beam X-ray
____ 18 _____ Other
____ 19 Bone Densitometer

E. Please Check one in each Category:

1. Practice

[ ] 1 Medical
[ ] 2 Dental
[ ] 3 Chiropractic
[ ] 4 Osteopathy
[ ] 5 Veterinary
[ ] 6 Podiatry
[ ] 7 Industrial
[ ] 8 Research
[ ] 9 Institution
[ ] 10 Other (Specify)

2. Facility Category

[ ] 1 Private Office
[ ] 2 Hospital
[ ] 3 Clinic
[ ] 4 Mobile (see F below)
[ ] 5 Education
[ ] 6 Industrial
[ ] 7 Institutional
[ ] 8 Specify _____

F. Van or Trailer I.D. No: _____ License Tag No. _____ Year: _____ State: _____

G. List all x-ray machines at the facility or in mobile van (Use additional sheets if necessary)

Console Brand Name _____ Model No._____ Serial No. _____

_____

H. List all x-ray systems that have been disposed of during the last report period: Console Brand Name _____

Disposition_____ If sold, name _____

I. For diagnostic Facilities except hospitals; List all practitioners who have the authority to prescribe x-rays. Please Print.

J. Only the person responsible for radiation safety may sign (i.e. the doctor in charge or RSO)

FOR DHR USE ONLY

Registration Number:

_____

_____
Authorized Signature/Title

_____
Print or Type Name

Date: _____

INSTRUCTIONS FOR COMPLETING SHIELDING DESIGN SPECIFICATIONS

Before Starting Form Look At Sample Drawing:

(1.) Prepare a scale drawing of your x-ray suite. Be sure to indicate locations of all doors and windows, operator=s area, and darkroom, including film storage.

(2.) Label all barriers alphabetically starting in the upper left corner of the room.

(3.) Indicate use of adjacent area outside each barrier.

(4.) The travel and traverse limits of the x-ray tube should be indicated, if applicable. Travel is defined as the long dimension of movement and traverse as the short dimension. Be sure to show travel and traverse on your drawing.

Completing the Shielding Design Specification Forms:

(1.) Complete applicant and facility information on top portion of form. Use one form for each room or x-ray machine. Include mailing address if different.

(2.) Indicate use of machine. This would be the type of examination or treatment performed using the machine.

(3.) Design workload. State either the milliamp-minutes per week at 100 kVp *or* estimate the number of exposures that will be made during an average one week period.

(4.) Indicate maximum exposure time, kVp setting, and maximum milliamp setting anticipated under usual operating techniques.

(5.) Column 1. Barrier Designation: Fill in the barrier designations from your scale drawing.

(6.) Column 2. Distance from X-ray tube to barrier.

(7.) Column 3. Primary or Secondary barrier.

Indicate whether the barrier is a primary or secondary radiation barrier. A primary barrier is defined as a barrier toward which the x-ray beam could be directed. All other barriers are secondary barriers.

(8.) Column 4. Identify use of adjacent area outside this barrier.

(9.) Column 5. Controlled or Noncontrolled Area.

The areas outside the x-ray room are either controlled access areas or noncontrolled access areas. A controlled area is a defined area in which the exposure of persons to radiation is under the supervision of a Radiation Protection Supervisor. This implies that the controlled area is one that requires control of access, occupancy, and working conditions for radiation protection purposes.

Areas which are not part of the Radiology Department or suite should not be declared controlled for the purpose of permitting reduction in degree of protection of occupants. Areas within the Department or suite which are not directly related to the use of radiation sources should not be declared controlled areas.

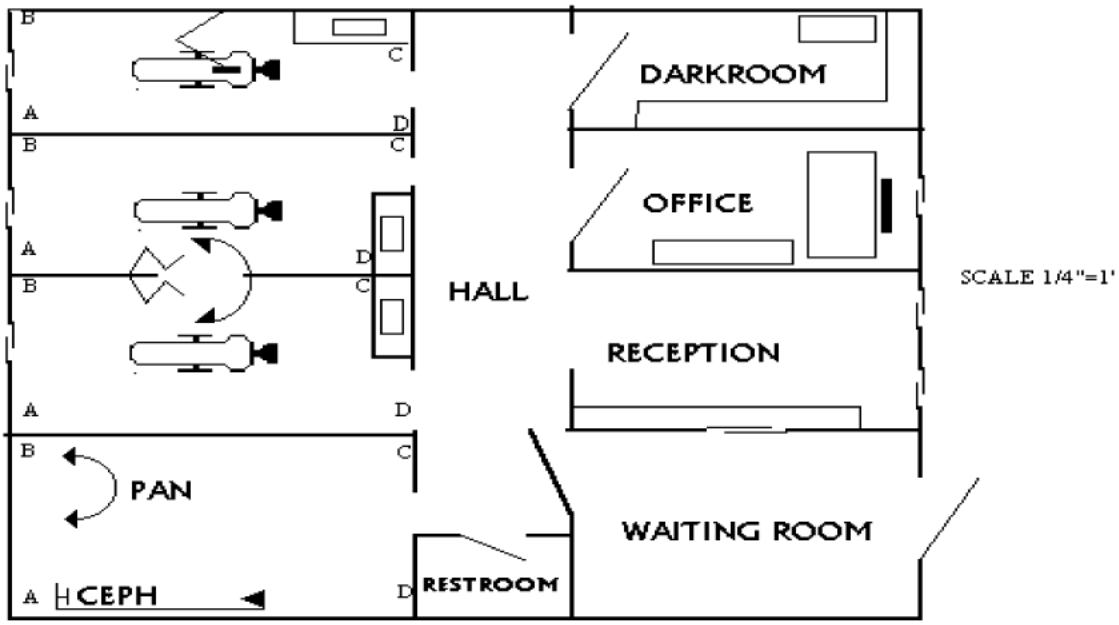
Any space not meeting the definition of a controlled area is a noncontrolled area.

(10.) Column 6. Construction Material and Thickness.

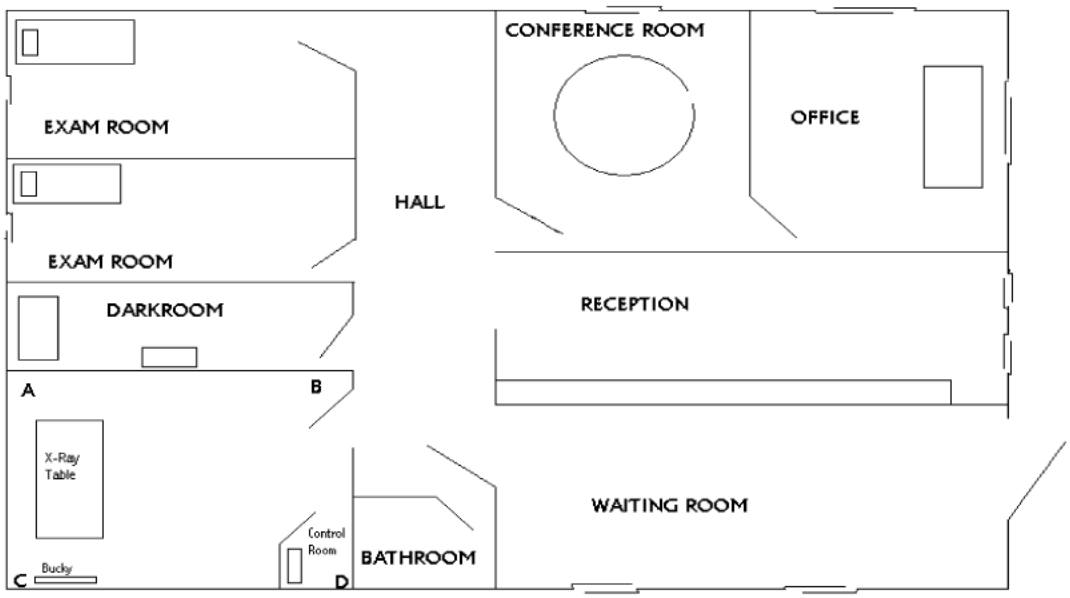
In order for Department staff to evaluate your shielding design, the construction materials and thicknesses of these materials at each barrier must be know. Be sure to include windows and doors.

As an example - for wall AB in our sample x-ray room there are two sheets of dry wall, 2 A thick each. (**Do not include studs and space between.**) In another example, the floor area which is located over a storage room is 2.5 inches of 147 pound concrete.

The addition of lead or other materials to reduce radiation exposure below regulatory requirements is to be indicated here. The amount of lead or lead equivalent material required can be calculated by using NCRP report 35.



SAMPLE DENTAL



Sample

Medical

SHIELDING DESIGN SPECIFICATION FORM

APPLICANT _____ **FACILITY NAME:** _____

ADDRESS _____ **MAILING ADDRESS (IF DIFFERENT)**

_____ _____

_____ _____

COUNTY _____ **TELEPHONE** _____

ROOM # _____ **USE OF MACHINE**

DESIGN WORKLOAD
IN MILLIAMP MIN/WEEK _____

MAXIMUM kVp SETTING
NORMALLY USED

OR

MAXIMUM NUMBER FILMS/WEEK
ANTICIPATED _____

MAXIMUM MILLIAMP SETTING
NMALLY USED_____

MAXIMUM EXPOSURE TIME
NORMALLY USED _____

PROJECTED OPENING DATE _____

BARRIER DESIGNATION	DISTANCE FROM X-RAY TUBE TO BARRIER	PRIMARY OR SECONDARY BARRIER	IDENTIFY USE OF ADJACENT AREA OUTSIDE THIS BARRIER	CONTROLLED OR NONCONTROLLED AREA	CONSTRUCTION MATERIAL AND THICKNESS
CEILING					
FLOOR					
OPERATION BARRIER					
WALL					
WALL					
WALL					
WALL					

REVISED 1/97

Instructions for Completing the X-Ray Self-Report Form
Department of Human Resources
Office of Regulatory Services
Health Care Section
Diagnostic Services Unit
Chapter 290-5-22-0.7 (2) and (4)

Reportable Incidents

This form is designed for notifying the Office of Regulatory Services (ORS) of reportable sentinel incidents and for the action taken by the facility to identify and address any opportunity to improve care / procedures related to the incident. A separate letter to notify ORS of such incidents is NOT required.

Directions for completing the x-ray Incident Report Form
Please type or print the information. Be as complete as you can: complete information may allow our staff to review the incident without contacting you for more information. Use a separate report for each incident: overexposure of a patient in one event, high count film badges of unknown exposure origin are separate incident.

What should be reported?

1. Any unanticipated patient death/serious harm due to excessive radiation
2. Misidentification of X-rays resulting in unnecessary surgery leading to problems that could have or did cause a health threat to the patients.

These are examples and are not meant to be an exhaustive list of reportable events.

Facility Information:
Include the name, address, phone number, fax number, and e-mail address of the facility. The license/registration number is on your facility license/certificate. The contact person(s) listed will be the person(s) ORS will contact should a follow-up phone call be needed.

Reporting Information:
Record the date and time the incident occurred, the date and time you became aware of the incident, and the date and time you are reporting the incident to ORS, circling am or pm. Check which event you ar reporting on the form or hand write it.

Summary of Incident:
Provide a brief summary of the reportable incident: describe what happened, who was involved (i.e. RT, CRTT, X-ray operator, phlebotomist, RN etc.) and what action was taken at the time of the event. For example:

"The operator took x-rays of the wrong patient because the patient chart was actually another patient's."

Immediate Corrective or Preventative Action Taken:
Provide a brief narrative of your evaluation of the actions taken in regard to the incident. Include any action you will take as a result of this review, which could include but is not limited to: inservices & monitoring, revision of policy/procedure, development of policy/procedure, no action required, etc.

Sign and date the form and print your name and title. Return the form via fax to (404)657-5442.
Do not put any information in the box entitled "for Department Use Only"

Thank you for your cooperation.

DHR

B. J. Walker, Commissioner

Georgia Department of Human Resources • Office of Regulatory Services • Sharon Dougherty, Director
Two Peachtree Street, NW • Suite 33.250 • Atlanta, Georgia 30303-3142
Phone: 404-657-5400 • Fax: 404-657-5442

PERSONAL IDENTIFICATION REQUIREMENTS

All application for state licensure and registration submitted after March 1, 2006, will require a notarized Personal Identification Affidavit. This Affidavit is for your X-ray facility. Please see the attached Affidavit and list of documents that establish identity.

Application, Shielding design and Affidavit **must be mail together.**
Please **do not fax** this will delay the registration process.

Please mail the original to:

Department of Human Resources
Office of Regulatory services
Health Care Section
2 Peachtree St, NW, Suite 33 -250
Atlanta, GA 30303-3142

ATTN: **X-ray Unit**

STATE OF GEORGIA)
)
COUNTY OF _____)

AFFIDAVIT

RE: PERSONAL IDENTIFICATION FOR LICENSURE / REGISTRATION

PERSONALLY APPEARED before the undersigned officer, duly authorized to administer oaths, came the undersigned, who after having been duly sworn, states under oath, the following:

1. That my name is _____and that I am who I say I am;

2. That my address is_____;

3. That I have presented sufficient personal identification to the notary that is true and accurate;

4. That I am legally in the United States of America;

5. That I am applying to the Georgia Department of Human Resources, Office of Regulatory Services, to operate a business/activity to be located at the following address:

_____ that is subject to regulation by the Department of Human Resources; and that this affidavit is a material part of the application; and

6. That if the Department subsequently determines that the material information contained in this affidavit is false, I will be in violation of licensing/registration requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me)
This _____day of _____, ____.)
)
)
)
_____)
NOTARY PUBLIC)
STATE OF GEORGIA)

_____
Affiant

My commission expires:_____.

LIST B
Documents That Establish Identity

For individuals 18 years of age or older:

- Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
- ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form I-179])
- School identification card with a photograph
- Voter's registration card
- United States military card or draft record
- Military dependent's identification card
- United States Coast Guard Merchant Mariner Card
- Native American tribal document
- Driver's license issued by a Canadian government authority

Source: http://uscis.gov/graphics/lawsregs/handbook/hand_emp.pdf US Handbook for Employers, page 23

DHR

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Phone: 404-657-5400 • Fax: 404-657-5442

DENTAL

Initial X-Ray Inspection

(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____

2. Does the x-ray tube head maintain its position during radiographic exposure? YES_____ NO_____ N/A_____

3. Is the open ended shielded cones the appropriate length 4" for 50KVP and less, 7" for KVP's greater than 50? YES___ NO___

4. The operator is able to stand a minimum of 6 feet from the useful beam or behind a protective barrier? YES___NO___

5. Is the operator able to view the patient during exposure? YES _____ NO _____

6. Are all controls properly labeled? YES ____ NO_____

7. Are the chemicals changed within a two month period and a permanent record maintained YES____NO____N/A____

8. Is the darkroom light tight? YES_____ NO _____

9. Does the darkroom have a safelight with correct wattage and filter bulb? YES_____ NO _____

10. Are film badges worn and a record maintained? YES _____ NO _____

11. Is there a warning statement on the x-ray machine? YES _____ NO _____

12. (a) Was an initial inspection / survey done by a qualified individual? YES_____ NO _____ N/A _____
    (b) Does the facility have the qualified individual's credentials on file? YES _____ NO _____

13. Is a copy of the qualified individuals credentials enclosed with this questionnaire? YES_____ NO _____

14. (a) Does the x-ray operator(s) have the 6 hours of mandatory radiation safety training and documentation YES___NO___
    (b) How many? _____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

Return this form to DHR- ORS Diagnostic Services Unit

DHR

B. J. Walker, Commissioner

Georgia Department of Human Resources • Office of Regulatory Services •
Two Peachtree Street, NW • Suite 33-250 • Atlanta, Georgia 30303-3142
Phone: 404-657-5400 • Fax: 404-657-5442

RADIOGRAPHIC

Initial X-Ray Inspection

(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____

2. Is the operator prevented from leaving the protected area of the booth (bone densitometer) YES _____ NO _____

3. Is the darkroom light tight? YES _____ NO _____ N/A _____

4. Does the safelight meet the film manufacturer's requirements:
   (a) correct wattage YES _____ NO _____ (b) the filter YES _____ NO ____

5. Is the a record of chemicals changed within a 2 month period and / or meets the manufacturer's suggestions and a record
   Maintained of change? YES _____ NO _____ N/A _____

6. Are film badges worn by operators and a record maintained of exposures? YES _____ NO _____

7. (a) Does the operator(s) have the 6 hour mandatory radiation safety training with written documentation YES ___ NO __
   (b) How many/ _____

8. Is there a lead apron available? YES _____ NO _____

9. Is the operator able to view the patient during exposure? YES _____ NO _____

10. (a) Was an initial inspection / survey done by a qualified individual YES _____ NO _____ N/A _____
    (b) Does the facility have the qualified individual's credentials on file? YES_____ NO _____

11. Is a copy of the qualified individuals report enclosed with this questionnaire? YES _____ NO_____

12. Is there a warning statement on the control panel? YES _____ NO _____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

Return this form to DHR- ORS Diagnostic Services Unit

DHR

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NON – MEDICAL
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____
2. Are radiation hazards area identified by warning signs? YES _____ NO _____
3. Are audible or visible signals in the vicinity of installations provided to warn of radiation? YES ____ NO ____ N/A ___
4. Do you have a copy of normal operating and emergency procedures? YES _____ NO _____
5. Does your x-ray machine have a key operated primary control switch that cannot be operated, if the key is removed? YES _____ NO _____
6. Does this area (open beam only) have caution signs posted? YES _____ NO _____
7. Does this facility (open beam only) have a cumulative direct reading device and film badges or equivalent provided and use by person(s) in this 5mR/hr area? YES _____ NO _____
8. Does the facility have the correct survey meter for quarterly safety checks? YES _____ NO _____
9. Does the x-ray machine have a warning light labeled **x-ray on** which lights only when the tube is activated and which Will prevent activation of the tube if it is not in working order? YES _____ NO _____ N/A _____
10. (a) Was an initial inspection / survey done by a qualified individual? YES _____ NO _____ N/A _____
    (b) Does the facility have the qualified individual's credentials on file? YES _____ NO _____
11. Is a copy of the qualified individuals report enclosed with this questionnaire? YES _____ NO _____
12. Does the x-ray operator(s) have the 2 hour mandatory safety training and documentation? YES_____ NO_____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

Return this form to DHR- ORS Diagnostic Services Unit

DHR

B. J. Walker, Commissioner

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VETERINARY

Initial X-Ray Inspection

(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____

2. Is the operator able to stand a minimum of 6 feet from the x-ray beam? YES_____ NO _____

3. Are there lead aprons and lead gloves available for all people in the room during radiographic exposure? YES___ NO___

4. Is the darkroom tight? YES _____ NO _____

5. Are the chemicals changed within a two-month period and a permanent record maintained? YES _____ NO _____

6. Is there a working safelight with the correct filter and wattage bulb? YES _____ NO _____

7. If hand processing is there a thermometer and timer available? YES _____ NO _____ N/A _____

8. Does the operator(s) have the 6 hour mandatory radiation safety training and documentation? YES _____ NO _____

9. Are film badges worn and records maintained? YES _____ NO _____ N/A _____

10. Does the machine have a warning statement? YES _____ NO _____

11. (a) Was an initial inspection / survey done by a qualified individual? YES _____ NO _____ N/A _____
    (b) Does the facility have the qualified individual's credentials on file? YES _____ NO _____

12. Is a copy of the qualified individual's report enclosed with this questionnaire? YES _____ NO _____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

Return this form to DHR- ORS Diagnostic Services Unit

DHR

B. J. Walker, Commissioner

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Two Peachtree Street, NW • Suite 33-250 • Atlanta, Georgia 30303-3142
Phone: 404-657-5400 • Fax: 404-657-5442

FLUOROSCOPE

Initial X-Ray Inspection

(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____

2. Does the facility have lead aprons available for person(s) assisting with the x-ray procedure? YES_____ NO _____

3. Does the facility have the annual entrance exposure radiation measurements posted in the room? YES _____ NO _____

4. Are film badges worn and records maintained? YES _____ NO _____

5. Does the x-ray operator(s) have the 6 hours mandatory radiation safety training and documentation? YES ____ NO ____

6. Does the x-ray machine have a warning statement? YES _____ NO _____

7. (a) Was a initial inspection / survey done by a qualified individual? YES _____ NO _____ N/A _____

   (b) Does the facility have the qualified individual's credentials on file? YES _____ NO _____

8. Is a copy of the qualified individuals report enclosed with this questionnaire? YES _____ NO _____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

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BONE DENSITOMETERS

Initial X-Ray Inspection

(Must be completed by a Qualified Individual)

CONTACT PERSON: _____ **PHONE** _____
(Type or Print)

NAM E OF FACILITY_____

ADDRESS OF FACILITY _____
(Street)

_____
(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: _____ - _____

Type of scanner: Full Body or Extremity

1. Have there been any changes in ownership? YES_____ NO_____ If yes, who was the previous owner? _____

2. Can the x-ray operator(s) get three feet from the beam when at the controls? YES _____ NO _____

3. Do you have area monitor for the full body? YES _____ NO _____

4. Do you have lead apron(s) available? YES _____ NO _____ N/A _____

5. Do the operator(s) have the 6 hours mandatory radiation safety training and documentation? YES ____ NO ____

6. Do you have a record of daily calibrations? YES _____ NO _____

7. Do you have an operator's manual? YES _____ NO _____

8. (a) Was a initial inspection / survey done by a qualified individual? YES _____ NO _____ N/A _____

   (b) Does the facility have the qualified individual's credentials on file? YES _____ NO _____

9. Is a copy of the qualified individuals report enclosed with this questionnaire? YES _____ NO _____

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations for X-ray.

Signature and Title of the responsible person_____

Return this form to DHR- ORS Diagnostic Services Unit