



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 Bureau of Environmental Health
 Radiation Control Program
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Registration Termination Form
Disposition of Medical X-Ray Unit(s)

Facility Name: _____

Address: _____

Telephone Number: _____

Radiation Control Number (RCN): _____

The following information is provided in accordance with 105 CMR 120.030: "Report of Changes". Complete the items below which are applicable to your registered unit(s).

1. The x-ray unit(s) authorized under the above referenced RCN # has been terminated. Attached is a copy of the receipt from the service provider that removed the unit(s).
2. The x-ray unit(s) was disposed of in the following manner: (please circle)
 (A.) Cut the x-ray cord
 (B.) Took to town's hazardous waste site
3. The x-ray unit(s) were transferred to:
 Name: _____
 Address: _____
 Telephone Number: _____

I, the owner of the x-ray unit(s), hereby certify that the x-ray unit(s) is no longer in my possession and request that the above referenced Registration be terminated.

Date: _____

Signature: _____

Title: _____