



MAMMOGRAPHY LICENSE #: M

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RADIATION CONTROL PROGRAM

MAMMOGRAPHY FACILITY LICENSE APPLICATION

1. FACILITY NAME: _____
2. STREET: _____ SUITE: _____
3. CITY: _____ 4. STATE: _____ 5. ZIP CODE: _____
6. TELEPHONE NUMBER: (____) _____ FAX NUMBER: (____) _____
7. RCN: _____ 8. MQSA CERTIFICATION #: _____

9. NAME OF OWNER/LICENSEE: _____
ADDRESS (IF DIFFERENT FROM ABOVE):
10. STREET: _____ SUITE: _____
11. CITY: _____ 12. STATE: _____ 13. ZIP CODE: _____
14. TELEPHONE NUMBER (____) _____ FAX NUMBER: _____
15. INDICATE COMPANY STRUCTURE (PLEASE CIRCLE):
"FOR PROFIT" CORPORATION "NOT FOR PROFIT" CORPORATION PARTNERSHIP SOLE PROPRIETORSHIP
TRUST
16. NAME OF CEO/PRESIDENT/SENIOR OFFICER: _____
17. TELEPHONE # OF CEO/PRESIDENT/SENIOR OFFICER: (____) _____
LIST ALL OTHER OFFICER(S) (NAME(S) AND POSITION(S)):

18. NUMBER OF MAMMOGRAPHY UNITS (PLEASE CIRCLE)

1 2 3 4 5 6

COMPLETE & RETURN ENCLOSED MAMMOGRAPHY MACHINE IDENTIFICATION FORM FOR EACH UNIT

FILM PROCESSOR (PLEASE ATTACH ADDITIONAL SHEETS IF MULTIPLE PROCESSORS):

19. MANUFACTURER: _____

20. MODEL #: _____ **21. MODEL YEAR:** _____

22. IS THE PROCESSOR DAYLIGHT LOADING: (YES) (NO)

23. IS THE PROCESSOR ONLY USED IN MAMMOGRAPHY: (YES) (NO)

RESPONSIBLE PHYSICIAN:

24. NAME: _____

25. MASS LICENSE #: _____ **26. EXPIRATION DATE:** _____

MEDICAL PHYSICIST:

27. NAME: _____

27.a. IS THE MEDICAL PHYSICIST A FULL TIME EMPLOYEE?	Y	N
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27.b. IS THE MEDICAL PHYSICIST A CONSULTANT?	Y	N
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PREFERRED MAILING ADDRESS:

28. STREET: _____ **29. CITY:** _____

30. STATE: _____ **31. ZIP CODE:** _____

**IF YOU HAVE ANY QUESTIONS CONCERNING THIS FORM, PLEASE CONTACT
KAREN FARRIS OR JOE CHADOROWSKY AT (617) 242-3035.**

PERSON COMPLETING FORM: _____

TELEPHONE NUMBER: () _____

FAX NUMBER: () _____

**THIS FORM SHOULD BE RETURNED TO:
RADIATION CONTROL PROGRAM
SCHRAFFTS CENTER, SUITE 1M2A
529 MAIN STREET
CHARLESTOWN, MA 02129**

I CERTIFY THAT:

1. I HAVE READ, UNDERSTAND AND WILL COMPLY WITH THE REQUIREMENTS OF 105 CMR 127.000.
2. TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS MADE AND INFORMATION DISCLOSED IN THIS LICENSE APPLICATION ARE TRUE, COMPLETE AND CORRECT.
3. IF ANY OF THE DISCLOSED INFORMATION CHANGES, I WILL PROVIDE UPDATED WRITTEN INFORMATION TO THE DEPARTMENT WITHIN 30 DAYS OF THE CHANGE, AS REQUIRED BY 105 CMR 127.029.
4. I WILL PROVIDE ADDITIONAL INFORMATION AS MAY BE REQUIRED BY THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH TO COMPLETE THE APPLICATION PROCESS, AS REQUIRED BY 105 CMR 127.023(C).

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY,

DATE

SIGNATURE OF LICENSEE APPLICANT (*Owner or person duly authorized to act on behalf of the owners*).

PRINT NAME AND TITLE

DATE

SIGNATURE OF LICENSEE APPLICANT DESIGNEE (*If applicable*)

PRINT NAME AND TITLE

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RADIATION CONTROL PROGRAM

MAMMOGRAPHY MACHINE IDENTIFICATION FORM

FACILITY NAME: _____

MASSACHUSETTS MAMMOGRAPHY LICENSE NUMBER: M _____

MAMMOGRAPHY MACHINE INFORMATION: (CHECK THE APPROPRIATE ITEMS)

1. THIS IS A BRAND NEW MAMMOGRAPHY MACHINE.
 THE MAMMOGRAPHY MACHIINE HAS A mAs METER.

2. UNIT MANUFACTURER: _____

3. UNIT MODEL: _____

4. DATE OF MANUFACTURE (MONTH AND YEAR); _____

5. SERIAL NUMBER: _____

6. DATE OF INSTALLATION: _____ PLANNED ACTUAL

7. DATE THAT YOU PLAN ON USING THE UNIT TO IMAGE PATIENTS: _____

8. DATE ACCREDITATION MATERIAL SUBMITTED TO ACR: _____

9. PLEASE INDICATE (CHECK ALL THAT ARE APPROPRIATE) HOW THIS X-RAY UNIT IS TO BE USED FOR BREAST DISEASE DETECTION OR SURGICAL PROCEDURES AT YOUR FACILITY:

<input type="checkbox"/> SCREENING ONLY	<input type="checkbox"/> STEREOTACTIC
<input type="checkbox"/> DIAGNOSTIC ONLY	<input type="checkbox"/> SPECIMEN
<input type="checkbox"/> DIAGNOSTIC & SCREENING	<input type="checkbox"/> RESEARCH EQUIPMENT
<input type="checkbox"/> STORED (INACTIVE)	<input type="checkbox"/> CABINET X-RAY
<input type="checkbox"/> NEEDLE LOCALIZATION	<input type="checkbox"/> OTHER (SPECIFY)

ADDITIONAL INFORMATION:

10. MACHINE SUPPLIER:
NAME: _____

ADDRESS: _____

11. MACHINE INSTALLER: (CHECK IF SAME AS SUPPLIER)
NAME: _____

ADDRESS: _____

12. SERVICE AGENT: (CHECK IF SAME AS SUPPLIER)
NAME: _____

ADDRESS: _____

13. FACILITY MAMMOGRAPHY UNIT STATUS: (CHECK ALL APPROPRIATE ITEMS)

- THIS MAMMOGRAPHY UNIT IS AN ADDITIONAL UNIT.
- THIS MAMMOGRAPHY UNIT REPLACES THE
(SPECIFY THE MANUFACTURER AND MODEL):

- THE REPLACED MAMMOGRAPHY UNIT:
 - WILL BE STORED AT OUR FACILITY, BUT NOT USED.
 - IS BEING RELOCATED TO ANOTHER FACILITY
(SPECIFY THE LICENSED FACILITY NAME AND "M" NUMBER)
_____ M# _____
 - HAS BEEN TRADED IN TO: (SPECIFY)

 - OTHER: _____

PERSON COMPLETING THIS FORM: (PLEASE PRINT)

NAME: _____

DATE: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____