MAMMOGRAPHY LICENSE #: M

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RADIATION CONTROL PROGRAM

MAMMOGRAPHY FACILITY LICENSE APPLICATION

Facility Name: _____

Street: _____ Suite: _____

City: _____ 4. State: _____ 5. Zip Code: _____

Telephone Number: (____)_____ Fax Number: (___)_____

Contact Person: _____

Email Address: _____

Name of Owner/Licensee:_____

A*ddress (if different from above):*

Street:_____ Suite:_____

City:_____ 12. State:_____ 13. Zip Code:_____

Telephone Number (___)_____ Fax Number: (___)_____

Email Address: _____

Indicate Company Structure (*please circle):*

"FOR PROFIT" CORPORATION "NOT FOR PROFIT" CORPORATION PARTNERSHIP SOLE PROPRIETORSHIP TRUST

Name of CEO/President/Senior Officer:_____

Telephone # of CEO/President/Senior Officer: (___)_____

List all other officers' names and positions:

_____

_____

Number of mammography units*):* _____

(**Complete & return a Mammography Machine Identification Form for each unit)**

Responsible Physician:

Name:_____

Mass License #: _____ Expiration Date: _____

Medical Physicist:

Name:_____

Is the medical physicist a full time employee? (YES) (NO)

Is the medical physicist a consultant? (YES) (NO)

Consultant Registration Number**:** **65-**_____

Preferred Mailing Address:

Street:_____ City:_____

State:_____ Zip Code:_____

Interpreting Physician	Mass License #	License Expiration Date

Mammography Radiologic Technologist ***Please note with an asterisk(*)*** **the Quality Assurance Technologist**	**Massachusetts Radiologic Technologist License Number**	**Mammography License Status** **(F) Full** **(T) Temporary**

If your mammography facility is mobile, indicate all geographic areas serviced: _____

_____

_____

If you have any questions concerning this form, please contact our office at (617) 242-3035.

Person Completing Form: _____

Telephone Number: (___) _____

Fax Number: (___) _____

This form should be returned to:

RADIATION CONTROL PROGRAM
SCHRAFFT 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