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)

- □ This is an **additional** mammography machine.
- □ This is a **replacement** mammography machine.

Unit Manufacturer:_____

Unit Model:_____

Month and Year of Manufacture:_____

Serial Number:_____

Date of Installation:_____ □ Planned □ Actual

Date that you plan on using the unit to image patients:_____

Date that the accreditation material was submitted to ACR:_____

Please indicate how this x-ray unit is to be used for breast disease detection or surgical procedures at your facility: (check all that are appropriate)

□ Screening Only	□ Stereotactic
□ Diagnostic Only	□ Specimen
□ Diagnostic & Screening	□ Research Equipment
□ Stored (Inactive)	□ Cabinet X-Ray
□ Needle Localization	□ Other (Specify)

Additional Information:

Machine Supplier:
Name:_____

Address:_____

Machine Installer: □ (Check if same as Supplier)
Name:_____

Address:_____

Service agent: □ (Check if same as Supplier)
Name:_____

Address:_____

Facility Mammography Unit Status: (Check all appropriate items)

□ This mammography unit replaces the:
(specify the **manufacturer, model, and serial number**):

_____

_____

□ 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:_____

E-mail Address:_____