MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RADIATION CONTROL PROGRAM
UPDATED INFORMATION FOR RADIATION SOURCES

FACILITY NAME: _________________________________

FACILITY ADDRESS: _________________________________

CITY, STATE, ZIP: _________________________________

PHONE NUMBER: _________________________________

RESPONSIBLE PERSON: _________________________________

EMAIL ADDRESS: _________________________________

CHECK OFF TYPE OF FACILITY USING CODES LISTED BELOW:

01- CHIROPRACTOR: ___ 06- PHYSICIAN: ___
02- CLINIC: ___ 07- PODIATRIST: ___
03- DENTAL OFFICE: ___ 08- PORTABLE: ___
04- EDUCATIONAL INSTITUTION: ___ 09- RADIOLOGIST: ___
05- HOSPITAL: ___ 10- VETERINARIAN: ___
06- OTHER: ___

HOW MANY OF THE FOLLOWING MACHINES TYPES DO YOU HAVE?

MEDICAL: DENTAL:

Radiography ______ Intraoral ______

Fluoro ______ Nomad hand held ______

Portables ______ Panorex ______

C-Arms ______ Pan/Ceph Combo ______

CT ______ Ceph Unit ______

Bone Density ______ Cone beam CT ______

THERAPY: ______ ANALYTICAL: ______

SIGNATURE: _________________________________ DATE: __________________

March 2018