Application For Registration Of Healing Arts Or Veterinary X-Ray Unit(s)

Division of Radiological Health

Submit one completed copy to: Mississippi State Department of Health
Division of Radiological Health
Post Office Box 1700
Jackson, Mississippi 39215-1700

1. Registrant (Name and Address): Telephone No.	2. Address at which registered unit(s) will be used: (If different from Item 1):
3. Company or Individual from whom x-ray equipment was purchased:	4. Category: ______________________ Therapy ______________________ Diagnostic ______________________ Other (Specify)
5. Manufacturer(s) — Use(s) *(See listing at bottom of page) 1) — 1) 2) — 2) 3) — 3)	6. Serial Number(s) of tube housing(s) — Model Number(s) of tube housing(s) 1) — 1) 2) — 2) 3) — 3)
7. Mode of Purchase: New _____________ Used _____________	8. Certification Status: Certified ________________ Non-certified ________________ Mixed ________________ (Certified & Non-certified components)
9. Individual responsible for radiation protection:	10. Total number of x-ray tubes (Including the above listed tube or tubes at your facility): _______________

Intended use(s)

General Purpose Radiography	Urology	Head-Neck *(Medical)*
General Purpose Fluoroscopy	Mammography	Dental - Intraoral
Tomography *(Other than CT)*	Chest	Dental - Cephalometric
Angiography	Chiropractic	Dental - Panoramic
Podiatry	CT Head Scanner	Radiation Therapy Simulator
	CT Whole Body Scanner	Any Other *(Specify in comments)*

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Signature

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Date