



# DHR

**B. J. Walker, Commissioner**

GEORGIA DEPARTMENT OF HUMAN RESOURCES • OFFICE OF REGULATORY SERVICES • HEALTH CARE SECTION  
TWO PEACHTREE STREET NW • SUITE 33-250 • ATLANTA GEORGIA 30303-3142 • (404) 657-5400 • FAX (404) 657-5442

## INSTRUCTIONS FOR X-RAY REGISTRATION

In accordance with the Radiation Control Act, Chapter 31-13 of the Official Code of Georgia Annotated, and the Rules and Regulations for X-Ray, Chapter 290-5-22, users of radiation machines are required to be registered with the Department prior to the operation of X-ray equipment in Georgia. An approved registration requires submission of a registration application, an approved shielding design, and an initial inspection.

The Department will acknowledge receipt of all relevant materials. Disapproved shielding designs will be returned for modification. Facility registration is not transferable, however an approved shielding design for a specified facility may be used by a subsequent owner for registration purposes, provided x-ray use is within specified conditions. **Relocations** require a new application, shielding design and an initial inspection.

Be advised that: **A FACILITY MAY NOT OPERATE X-RAY MACHINES UNTIL AN INITIAL INSPECTION IS DONE. FAILURE TO REGISTER YOUR MACHINES IN ACCORDANCE WITH REGULATIONS WILL CAUSE YOU TO BE SUBJECT TO CIVIL MONEY PENALTIES NOT TO EXCEED \$1,000.00 OR DENIAL OF REGISTRATION OR BOTH.** Due to a backlog of inspections, the X-ray Unit is approximately six weeks behind in completing initial inspections. If you wish to operate the X-ray equipment sooner, you may opt to have an individual qualified at § § 290-5-22-.02(1)(d) and .02(4) to perform the initial inspection at your own expense.

Enclosed is a package of information that contains forms and materials that you are required to submit to this Office within (30) days. The materials included are:

- \_\_\_ 1. **Rules and Regulations for X-Rays**      [www.ors.dhr.georgia.gov](http://www.ors.dhr.georgia.gov)  
Click on **SERVICES** Click on **PRIMARY HEALTH CARE** Scroll down Click on **X-RAY FACILITIES** Scroll down to **Rules and Regs.**
- \_\_\_ 2. Shielding Design Format Requirements with example
- \_\_\_ 3. Reportable Incidents Instruction
- \_\_\_ 4. Initial Inspection Form

Any questions concerning the requirements in this letter may be addressed by calling 404-657-5400. To aid you in completing the forms, directions are enclosed in your packet.



**APPLICATION FOR X-RAY REGISTRATION**

**A. Applicant:** \_\_\_\_\_ **Facility** \_\_\_\_\_  
 (Please Print or Type)

**Facility Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Telephone ( )** \_\_\_\_\_ **Fax ( )** \_\_\_\_\_

**B. Has a Radiation Shielding Design for this facility been submitted to the X-ray Unit for approval: A plan must be submitted as part of the initial registration requirements:**  Yes  No If yes, plan review no. \_\_\_\_\_

**C. Is This Application for:** (check all that apply)

<input type="checkbox"/> A new Facility	<input type="checkbox"/> Relocation	Have you previously registered an X-ray Facility in Georgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A purchase of new equipment	<input type="checkbox"/> Update information of previously registered	If yes, under what name: _____
	<input type="checkbox"/> Other _____	And in what county: _____

**D. Equipment type:** (Indicate the number of machines in each category):

- |   |                                |   |
|---|--------------------------------|---|
| ____ 1 Dental Intraoral                 | ____ 7 Mammography             | ____ 13 Therapeutic (less than 0.9 Mev) |
| ____ 2 Dental Cephalometric             | ____ 8 C-Arm                   | ____ 14 Therapeutic Accelerator         |
| ____ 3 Dental Panorgraphic              | ____ 9 Computerized Tomography | ____ 15 Particle Accelerator            |
| ____ 4 Radiographic Only                | ____ 10 Photofluorographic     | ____ 16 Cabinet X-ray                   |
| ____ 5 Fluoroscopic Only                | ____ 11 Analytical X-ray       | ____ 17 Open Beam X-ray                 |
| ____ 6 R & F Same Unit No of tubes ____ | ____ 12 Particle Analyzer      | ____ 18 _____ Other                     |
|   |                                | ____ 19 Bone Densitometer               |

**E. Please Check one in each Category:**

**1. Practice**

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Medical      | <input type="checkbox"/> 6 Podiatry         |
| <input type="checkbox"/> 2 Dental       | <input type="checkbox"/> 7 Industrial       |
| <input type="checkbox"/> 3 Chiropractic | <input type="checkbox"/> 8 Research         |
| <input type="checkbox"/> 4 Osteopathy   | <input type="checkbox"/> 9 Institution      |
| <input type="checkbox"/> 5 Veterinary   | <input type="checkbox"/> 10 Other (Specify) |

**2. Facility Category**

- |   |  |
|---|--|
| <input type="checkbox"/> 1 Private Office       | <input type="checkbox"/> 5 Education     |
| <input type="checkbox"/> 2 Hospital             | <input type="checkbox"/> 6 Industrial    |
| <input type="checkbox"/> 3 Clinic               | <input type="checkbox"/> 7 Institutional |
| <input type="checkbox"/> 4 Mobile (see F below) | <input type="checkbox"/> 8 Specify _____ |

**F. Van or Trailer I.D. No:** \_\_\_\_\_ **License Tag No.** \_\_\_\_\_ **Year:** \_\_\_\_\_ **State:** \_\_\_\_\_

**G. List all x-ray machines at the facility or in mobile van ( Use additional sheets if necessary)**

**Console Brand Name** \_\_\_\_\_ **Model No.** \_\_\_\_\_ **Serial No.** \_\_\_\_\_

**H. List all x-ray systems that have been disposed of during the last report period: Console Brand Name** \_\_\_\_\_

**Disposition** \_\_\_\_\_ **If sold, name** \_\_\_\_\_

**I. For diagnostic Facilities except hospitals; List all practitioners who have the authority to prescribe x-rays. Please Print.**

**J. Only the person responsible for radiation safety may sign (i.e. the doctor in charge or RSO)**

**FOR DHR USE ONLY**

**Registration Number:**

\_\_\_\_\_

\_\_\_\_\_  
 Authorized Signature/Title

\_\_\_\_\_  
 Print or Type Name

Date: \_\_\_\_\_

## **INSTRUCTIONS FOR COMPLETING SHIELDING DESIGN SPECIFICATIONS**

### **Before Starting Form Look At Sample Drawing:**

- (1.) Prepare a scale drawing of your x-ray suite. Be sure to indicate locations of all doors and windows, operator=s area, and darkroom, including film storage.
- (2.) Label all barriers alphabetically starting in the upper left corner of the room.
- (3.) Indicate use of adjacent area outside each barrier.
- (4.) The travel and traverse limits of the x-ray tube should be indicated, if applicable. Travel is defined as the long dimension of movement and traverse as the short dimension. Be sure to show travel and traverse on your drawing.

### **Completing the Shielding Design Specification Forms:**

- (1.) Complete applicant and facility information on top portion of form. Use one form for each room or x-ray machine. Include mailing address if different.
- (2.) Indicate use of machine. This would be the type of examination or treatment performed using the machine.
- (3.) Design workload. State either the milliamp-minutes per week at 100 kVp or estimate the number of exposures that will be made during an average one week period.
- (4.) Indicate maximum exposure time, kVp setting, and maximum milliamp setting anticipated under usual operating techniques.
- (5.) Column 1. Barrier Designation: Fill in the barrier designations from your scale drawing.
- (6.) Column 2. Distance from X-ray tube to barrier.
- (7.) Column 3. Primary or Secondary barrier.

Indicate whether the barrier is a primary or secondary radiation barrier. A primary barrier is defined as a barrier toward which the x-ray beam could be directed. All other barriers are secondary barriers.

- (8.) Column 4. Identify use of adjacent area outside this barrier.
- (9.) Column 5. Controlled or Noncontrolled Area.

The areas outside the x-ray room are either controlled access areas or noncontrolled access areas. A controlled area is a defined area in which the exposure of persons to radiation is under the supervision of a Radiation Protection Supervisor. This implies that the controlled area is one that requires control of access, occupancy, and working conditions for radiation protection purposes.

Areas which are not part of the Radiology Department or suite should not be declared controlled for the purpose of permitting reduction in degree of protection of occupants. Areas within the Department or suite which are not directly related to the use of radiation sources should not be declared controlled areas.

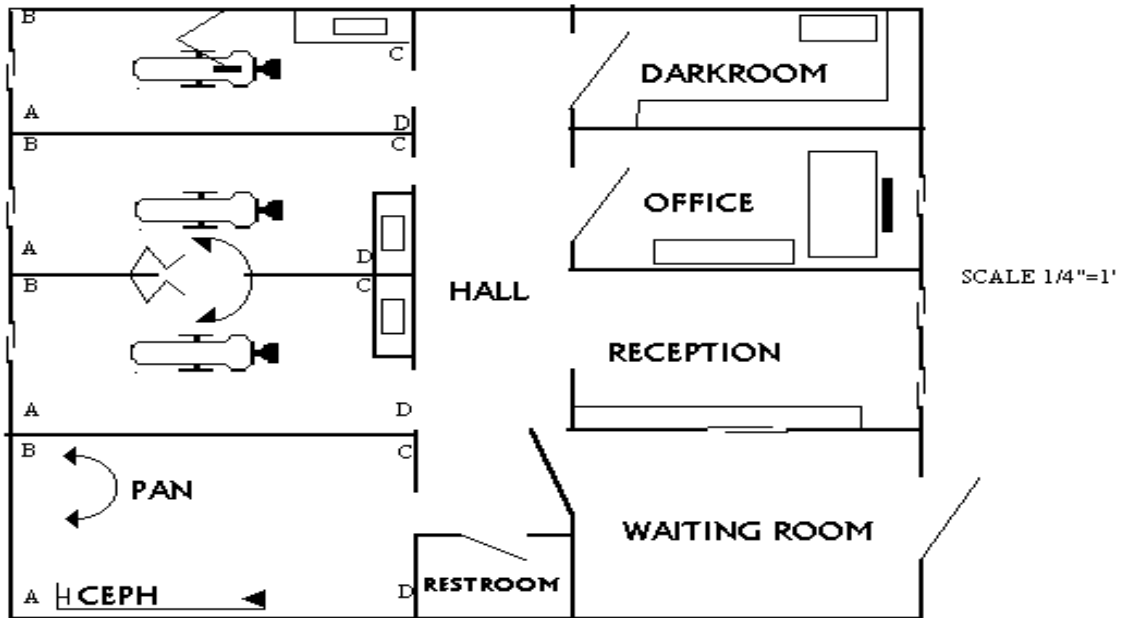
Any space not meeting the definition of a controlled area is a noncontrolled area.

- (10.) Column 6. Construction Material and Thickness.

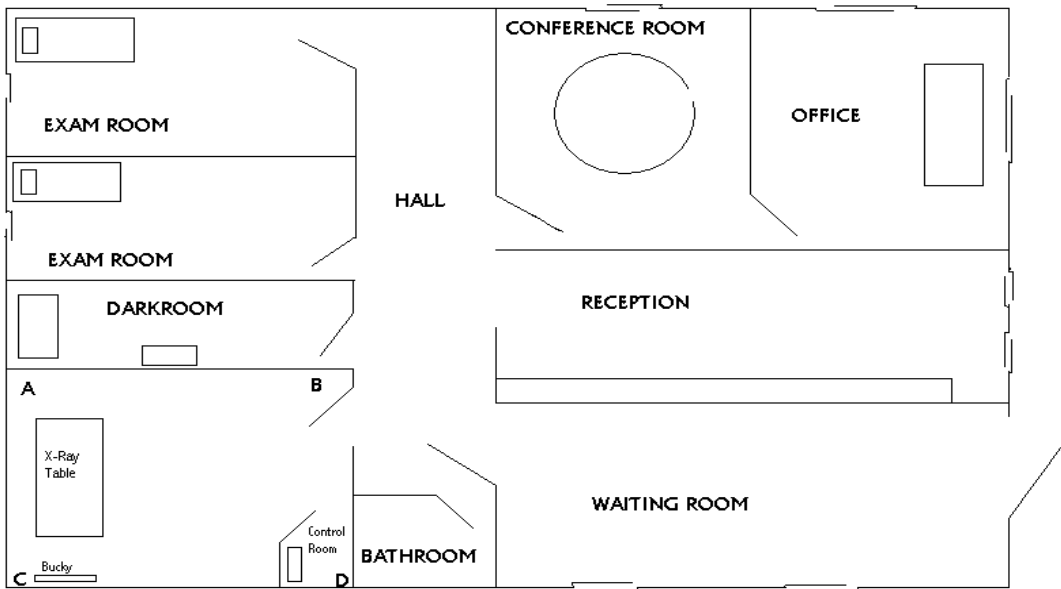
In order for Department staff to evaluate your shielding design, the construction materials and thicknesses of these materials at each barrier must be known. Be sure to include windows and doors.

As an example - for wall AB in our sample x-ray room there are two sheets of dry wall, 2 A thick each. (**Do not include studs and space between.**) In another example, the floor area which is located over a storage room is 2.5 inches of 147 pound concrete.

The addition of lead or other materials to reduce radiation exposure below regulatory requirements is to be indicated here. The amount of lead or lead equivalent material required can be calculated by using NCRP report 35.



**SAMPLE DENTAL**



**Medical**

**Sample**

**SHIELDING DESIGN SPECIFICATION FORM**

APPLICANT \_\_\_\_\_ FACILITY NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_ MAILING ADDRESS (IF DIFFERENT) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

COUNTY \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ROOM # \_\_\_\_\_ USE OF MACHINE \_\_\_\_\_

DESIGN WORKLOAD IN MILLIAMP MIN/WEEK \_\_\_\_\_ MAXIMUM kVp SETTING NORMALLY USED \_\_\_\_\_

OR

MAXIMUM NUMBER FILMS/WEEK ANTICIPATED \_\_\_\_\_ MAXIMUM MILLIAMP SETTING NORMALLY USED \_\_\_\_\_

MAXIMUM EXPOSURE TIME NORMALLY USED \_\_\_\_\_

PROJECTED OPENING DATE \_\_\_\_\_

BARRIER DESIGNATION	DISTANCE FROM X-RAY TUBE TO BARRIER	PRIMARY OR SECONDARY BARRIER	IDENTIFY USE OF ADJACENT AREA OUTSIDE THIS BARRIER	CONTROLLED OR NONCONTROLLED AREA	CONSTRUCTION MATERIAL AND THICKNESS
CEILING					
FLOOR					
OPERATION BARRIER					
WALL					
WALL					
WALL					
WALL					

**Instructions for Completing the X-Ray Self-Report Form**  
**Department of Human Resources**  
**Office of Regulatory Services**  
**Health Care Section**  
**Diagnostic Services Unit**  
**Chapter 290-5-22-0.7 (2) and (4)**

**Reportable Incidents**

This form is designed for notifying the Office of Regulatory Services (ORS) of reportable sentinel incidents and for the action taken by the facility to identify and address any opportunity to improve care / procedures related to the incident. A separate letter to notify ORS of such incidents is NOT required.

**Directions for completing the x-ray Incident Report Form**

Please type or print the information. Be as complete as you can: complete information may allow our staff to review the incident without contacting you for more information. Use a separate report for each incident: overexposure of a patient in one event, high count film badges of unknown exposure origin are separate incident.

**What should be reported?**

1. Any unanticipated patient death/serious harm due to excessive radiation
2. Misidentification of X-rays resulting in unnecessary surgery leading to problems that could have or did cause a health threat to the patients.

These are examples and are not meant to be an exhaustive list of reportable events.

**Facility Information:**

Include the name, address, phone number, fax number, and e-mail address of the facility. The license/registration number is on your facility license/certificate. The contact person(s) listed will be the person(s) ORS will contact should a follow-up phone call be needed.

**Reporting Information:**

Record the date and time the incident occurred, the date and time you became aware of the incident, and the date and time you are reporting the incident to ORS, circling am or pm. Check which event you are reporting on the form or hand write it.

**Summary of Incident:**

Provide a brief summary of the reportable incident: describe what happened, who was involved (i.e. RT, CRTT, X-ray operator, phlebotomist, RN etc.) and what action was taken at the time of the event. For example:

*"The operator took x-rays of the wrong patient because the patient chart was actually another patient's."*

**Immediate Corrective or Preventative Action Taken:**

Provide a brief narrative of your evaluation of the actions taken in regard to the incident. Include any action you will take as a result of this review, which could include but is not limited to: inservices & monitoring, revision of policy/procedure, development of policy/procedure, no action required, etc.

**Sign and date the form** and print your name and title. Return the form via fax to (404)657-5442. Do not put any information in the box entitled "for Department Use Only"

Thank you for your cooperation.



**B. J. Walker, Commissioner**

Georgia Department of Human Resources • Office of Regulatory Services • Sharon Dougherty, Director  
Two Peachtree Street, NW • Suite 33.250 • Atlanta, Georgia 30303-3142  
Phone: 404-657-5400 • Fax: 404-657-5442

## **PERSONAL IDENTIFICATION REQUIREMENTS**

All application for state licensure and registration submitted after March 1, 2006, will require a notarized Personal Identification Affidavit. This Affidavit is for your X-ray facility. Please see the attached Affidavit and list of documents that establish identity.

Application, Shielding design and Affidavit **must be mail together.**  
Please **do not fax** this will delay the registration process.

### **Please mail the original to:**

Department of Human Resources  
Office of Regulatory services  
Health Care Section  
2 Peachtree St, NW, Suite 33 -250  
Atlanta, GA 30303-3142

ATTN: **X-ray Unit**



## **LIST B**

### **Documents That Establish Identity**

For individuals 18 years of age or older:

- Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
- ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form I-179])
- School identification card with a photograph
- Voter's registration card
- United States military card or draft record
- Military dependent's identification card
- United States Coast Guard Merchant Mariner Card
- Native American tribal document
- Driver's license issued by a Canadian government authority



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DENTAL
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: (Type or Print) PHONE

NAME OF FACILITY

ADDRESS OF FACILITY (Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: -

- 1. Have there been any changes in ownership? YES NO If yes, who was the previous owner?
2. Does the x-ray tube head maintain its position during radiographic exposure? YES NO N/A
3. Is the open ended shielded cones the appropriate length 4" for 50KVP and less, 7" for KVP's greater than 50? YES NO
4. The operator is able to stand a minimum of 6 feet from the useful beam or behind a protective barrier? YES NO
5. Is the operator able to view the patient during exposure? YES NO
6. Are all controls properly labeled? YES NO
7. Are the chemicals changed within a two month period and a permanent record maintained YES NO N/A
8. Is the darkroom light tight? YES NO
9. Does the darkroom have a safelight with correct wattage and filter bulb? YES NO
10. Are film badges worn and a record maintained? YES NO
11. Is there a warning statement on the x-ray machine? YES NO
12. (a) Was an initial inspection / survey done by a qualified individual? YES NO N/A
(b) Does the facility have the qualified individual's credentials on file? YES NO
13. Is a copy of the qualified individuals credentials enclosed with this questionnaire? YES NO
14. (a) Does the x-ray operator(s) have the 6 hours of mandatory radiation safety training and documentation YES NO
(b) How many?

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray
Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations
for X-ray.

Signature and Title of the responsible person



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RADIOGRAPHIC
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_
(Type or Print)

NAME OF FACILITY \_\_\_\_\_

ADDRESS OF FACILITY \_\_\_\_\_
(Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: \_\_\_\_\_ - \_\_\_\_\_

- 1. Have there been any changes in ownership? YES \_\_\_\_ NO \_\_\_\_ If yes, who was the previous owner?
2. Is the operator prevented from leaving the protected area of the booth (bone densitometer) YES \_\_\_\_ NO \_\_\_\_
3. Is the darkroom light tight? YES \_\_\_\_ NO \_\_\_\_ N/A \_\_\_\_
4. Does the safelight meet the film manufacturer's requirements:
(a) correct wattage YES \_\_\_\_ NO \_\_\_\_ (b) the filter YES \_\_\_\_ NO \_\_\_\_
5. Is the a record of chemicals changed within a 2 month period and / or meets the manufacturer's suggestions and a record
Maintained of change? YES \_\_\_\_ NO \_\_\_\_ N/A \_\_\_\_
6. Are film badges worn by operators and a record maintained of exposures? YES \_\_\_\_ NO \_\_\_\_
7. (a) Does the operator(s) have the 6 hour mandatory radiation safety training with written documentation YES \_\_\_\_ NO \_\_\_\_
(b) How many/ \_\_\_\_\_
8. Is there a lead apron available? YES \_\_\_\_ NO \_\_\_\_
9. Is the operator able to view the patient during exposure? YES \_\_\_\_ NO \_\_\_\_
10. (a) Was an initial inspection / survey done by a qualified individual YES \_\_\_\_ NO \_\_\_\_ N/A \_\_\_\_
(b) Does the facility have the qualified individual's credentials on file? YES \_\_\_\_ NO \_\_\_\_
11. Is a copy of the qualified individuals report enclosed with this questionnaire? YES \_\_\_\_ NO \_\_\_\_
12. Is there a warning statement on the control panel? YES \_\_\_\_ NO \_\_\_\_

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Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations
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Signature and Title of the responsible person \_\_\_\_\_



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NON – MEDICAL
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_
(Type or Print)

NAME OF FACILITY \_\_\_\_\_

ADDRESS OF FACILITY \_\_\_\_\_
(Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: \_\_\_\_\_ - \_\_\_\_\_

- 1. Have there been any changes in ownership? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, who was the previous owner?
2. Are radiation hazards area identified by warning signs? YES \_\_\_\_\_ NO \_\_\_\_\_
3. Are audible or visible signals in the vicinity of installations provided to warn of radiation? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
4. Do you have a copy of normal operating and emergency procedures? YES \_\_\_\_\_ NO \_\_\_\_\_
5. Does your x-ray machine have a key operated primary control switch that cannot be operated, if the key is removed?
YES \_\_\_\_\_ NO \_\_\_\_\_
6. Does this area (open beam only) have caution signs posted? YES \_\_\_\_\_ NO \_\_\_\_\_
7. Does this facility (open beam only) have a cumulative direct reading device and film badges or equivalent provided and
use by person(s) in this 5mR/hr area? YES \_\_\_\_\_ NO \_\_\_\_\_
8. Does the facility have the correct survey meter for quarterly safety checks? YES \_\_\_\_\_ NO \_\_\_\_\_
9. Does the x-ray machine have a warning light labeled x-ray on which lights only when the tube is activated and which
Will prevent activation of the tube if it is not in working order? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
10. (a) Was an initial inspection / survey done by a qualified individual? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
(b) Does the facility have the qualified individual's credentials on file? YES \_\_\_\_\_ NO \_\_\_\_\_
11. Is a copy of the qualified individuals report enclosed with this questionnaire? YES \_\_\_\_\_ NO \_\_\_\_\_
12. Does the x-ray operator(s) have the 2 hour mandatory safety training and documentation? YES \_\_\_\_\_ NO \_\_\_\_\_

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray
Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations
for X-ray.

Signature and Title of the responsible person \_\_\_\_\_



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VETERINARY
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_
(Type or Print)

NAME OF FACILITY \_\_\_\_\_

ADDRESS OF FACILITY \_\_\_\_\_
(Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: \_\_\_\_\_ - \_\_\_\_\_

- 1. Have there been any changes in ownership? YES\_\_\_\_\_ NO\_\_\_\_\_ If yes, who was the previous owner?
2. Is the operator able to stand a minimum of 6 feet from the x-ray beam? YES\_\_\_\_\_ NO \_\_\_\_\_
3. Are there lead aprons and lead gloves available for all people in the room during radiographic exposure? YES\_\_\_ NO\_\_\_
4. Is the darkroom tight? YES \_\_\_\_\_ NO \_\_\_\_\_
5. Are the chemicals changed within a two-month period and a permanent record maintained? YES \_\_\_\_\_ NO \_\_\_\_\_
6. Is there a working safelight with the correct filter and wattage bulb? YES \_\_\_\_\_ NO \_\_\_\_\_
7. If hand processing is there a thermometer and timer available? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
8. Does the operator(s) have the 6 hour mandatory radiation safety training and documentation? YES \_\_\_\_\_ NO \_\_\_\_\_
9. Are film badges worn and records maintained? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
10. Does the machine have a warning statement? YES \_\_\_\_\_ NO \_\_\_\_\_
11. (a) Was an initial inspection / survey done by a qualified individual? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
(b) Does the facility have the qualified individual's credentials on file? YES \_\_\_\_\_ NO \_\_\_\_\_
12. Is a copy of the qualified individual's report enclosed with this questionnaire? YES \_\_\_\_\_ NO \_\_\_\_\_

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray
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Signature and Title of the responsible person \_\_\_\_\_



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FLUOROSCOPE
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_
(Type or Print)

NAM E OF FACILITY \_\_\_\_\_

ADDRESS OF FACILITY \_\_\_\_\_
(Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: \_\_\_\_\_ - \_\_\_\_\_

- 1. Have there been any changes in ownership? YES \_\_\_\_ NO \_\_\_\_ If yes, who was the previous owner?
2. Does the facility have lead aprons available for person(s) assisting with the x-ray procedure? YES \_\_\_\_ NO \_\_\_\_
3. Does the facility have the annual entrance exposure radiation measurements posted in the room? YES \_\_\_\_ NO \_\_\_\_
4. Are film badges worn and records maintained? YES \_\_\_\_ NO \_\_\_\_
5. Does the x-ray operator(s) have the 6 hours mandatory radiation safety training and documentation? YES \_\_\_\_ NO \_\_\_\_
6. Does the x-ray machine have a warning statement? YES \_\_\_\_ NO \_\_\_\_
7. (a) Was a initial inspection / survey done by a qualified individual? YES \_\_\_\_ NO \_\_\_\_ N/A \_\_\_\_
(b) Does the facility have the qualified individual's credentials on file? YES \_\_\_\_ NO \_\_\_\_
8. Is a copy of the qualified individuals report enclosed with this questionnaire? YES \_\_\_\_ NO \_\_\_\_

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BONE DENSITOMETERS
Initial X-Ray Inspection
(Must be completed by a Qualified Individual)

CONTACT PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_
(Type or Print)

NAME OF FACILITY \_\_\_\_\_

ADDRESS OF FACILITY \_\_\_\_\_
(Street)

(City) (State) (Zip Code) (County)

REGISTRATION NUMBER: \_\_\_\_\_ - \_\_\_\_\_

Type of scanner: Full Body or Extremity

- 1. Have there been any changes in ownership? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, who was the previous owner?
2. Can the x-ray operator(s) get three feet from the beam when at the controls? YES \_\_\_\_\_ NO \_\_\_\_\_
3. Do you have area monitor for the full body? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Do you have lead apron(s) available? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
5. Do the operator(s) have the 6 hours mandatory radiation safety training and documentation? YES \_\_\_\_\_ NO \_\_\_\_\_
6. Do you have a record of daily calibrations? YES \_\_\_\_\_ NO \_\_\_\_\_
7. Do you have an operator's manual? YES \_\_\_\_\_ NO \_\_\_\_\_
8. (a) Was a initial inspection / survey done by a qualified individual? YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_
(b) Does the facility have the qualified individual's credentials on file? YES \_\_\_\_\_ NO \_\_\_\_\_
9. Is a copy of the qualified individuals report enclosed with this questionnaire? YES \_\_\_\_\_ NO \_\_\_\_\_

I attest that the information provided above is true and accurate.
I further understand that making a false statement with respect to the material facts on this document may result in X-ray
Licensure enforcement sanctions being imposed against this facility as found in Chapter 290-5-22.08 of the Georgia Rules and Regulations
for X-ray.

Signature and Title of the responsible person \_\_\_\_\_