



Application for Medical Oncology or Industrial X-Ray Machine Registration

INSTRUCTIONS: Complete all items if this is an Initial Application. Use supplemental sheets where necessary. A link <https://hhs.iowa.gov/public-health/radiological-health> to the HHS Radiation Machines and Radioactive Materials rules can be found at that web site. To ensure a complete and accurate application, please use the appropriate regulatory guide as a reference while completing this application.

Application can be e-mailed to iowaram@hhs.iowa.gov. Payment can be made by credit card on the regulatory portal at <https://amanda-portal.idph.state.ia.us/adpereh/portal/#/dashboards/index> following email submission and Agency processing. Otherwise, check payment and, if applicable, paper application can be mailed to:

Iowa Department of Health & Human Services, Bureau of Radiological Health, Lucas State Office Building, 5th floor, 321 East 12th street, Des Moines, IA, 50319

Upon approval, the applicant will receive an Iowa Reciprocity Recognition of your Radioactive Materials License issued in accordance with the general requirements contained in chapter 136C of the Iowa administrative code.

Need Assistance? Email iowaram@hhs.iowa.gov or call the Agency at numbers listed at <https://hhs.iowa.gov/public-health/radiological-health/radioactive-materials-program>.

FACILITY INFORMATION: PLEASE PRINT OR TYPE.

Facility Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip: * _____

Phone Number 1: * _____ Phone Number 2: _____

Email: * _____ EIN: * _____

AFFIRMATION QUESTIONS:

Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, Yes No suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you or the organization? *

If yes, include the date, location, reason, and resolution. *

_____ Yes No
Have there ever been judgments or settlements paid on your behalf or on the organization's behalf as a result of a professional liability case? *

If yes, include the date, location, reason, and resolution. *

Have you or the organization ever had a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body? *
 If yes, provide a description of the circumstances. *

Yes No

CONTACT INFORMATION

First Name: * _____ Last Name: * _____
 Phone Number: * _____ Email: * _____
 License Number: _____ Business Name: * _____
 Street Address: * _____
 City: * _____ State: * _____ Zip Code: * _____
 Comments: _____

EQUIPMENT DESCRIPTION: List each type of device separately. (Print and Complete additional pages if necessary.)

EQUIPMENT TYPES: Below are equipment types that are available.

Food Sterilization Accelerator, Electron Microscope, CT Simulator, Superficial, Analytical X-ray Baggage x-ray, Cabinet x-ray, Electronic Brachytherapy, Industrial Radiography x-ray, Medical Accelerator, Non- Medical Accelerator, Portable x-ray, Walk-in Cabinet x-ray, x-ray Fluorescence, Other.

Equipment Type	
Manufacturer Name:	
Model Number of the Equipment	
Serial Number of the device	
Date Installed	
Shielding Documentation Attached	<input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> N/A

Equipment Type	
Manufacturer Name:	
Model Number of the Equipment	
Serial Number of the device	
Date Installed	
Shielding Documentation Attached	<input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> N/A

Equipment Type	
Manufacturer Name:	
Model Number of the Equipment	
Serial Number of the device	
Date Installed	
Shielding Documentation Attached	<input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> N/A

Equipment Type	
Manufacturer Name:	
Model Number of the Equipment	
Serial Number of the device	
Date Installed	
Shielding Documentation Attached	<input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> N/A

I am authorized to complete this application on behalf of the organization.

As representative of the organization, I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. As said representative of the organization, I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning this application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that a representative of the organization is responsible to update information submitted herewith if the response or the information changes.

In submitting this application, the organization agrees to any reasonable inquiry that may be necessary to verify or clarify the information provided on or in conjunction with this application.

I understand this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this license, permit, registration, or certification and will make employees aware as required and will comply with those provisions

Typed/Printed Name

Signature Certifying Officer

Title

Date