



RADIATION MACHINE FACILITY REGISTRATION CHANGE REQUEST

Registration number - _____

Fill out all applicable sections of RC FORM 201. Sign and date the form, then mail to: **Arkansas Department of Health, Radiation Control Section, X-ray Program, 4815 W. Markham Street, Slot 30, Little Rock, Arkansas, 72205-3867**. Submissions not requiring a fee can also be faxed to (501) 661-2849. Please print or type all entries. For questions, call the X-ray Program at (501) 661-2378.

Facility Name:	Facility Physical Address: <i>(Previous location if moved)</i>
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❖ **Report of Changes:**

RH-26 of the ASBH Rules for Control of Sources of Ionizing Radiation states that the registrant shall notify the Department in writing if there is a change in facility name, mailing address, location of the x-ray unit(s), and the receipt, sale, or disposal of a radiation machine. Notification is required within ten **(10) days** of a change, unless the change involves a therapeutic radiation machine. These changes must be reported in writing to the Department prior to the change being made.

<input type="checkbox"/> Change of facility name	New facility name:
<input type="checkbox"/> Change of address (physical or mailing) <i>(circle one)</i>	New address:

Addition of new x-ray units: *(Machine Use Codes listed on second page)*
In accordance with RH-58, a fee of **\$65.00** shall be paid per x-ray tube, up to a maximum of \$260.00 for 4 tubes. If there are 4 or more tubes currently listed on your registration, you are not required to submit payment. If you have less than 4 tubes, please submit the appropriate fee with your change request (check or money order).

Room Location of Unit	Machine Use Code	Control Panel Manufacturer	Control Panel Model Name and Number	Control Panel Serial No.	No. of Tubes

❖ **Report of Discontinuance:**

RH-27 requires that every registrant who discontinues the use of, or permanently disposes of reportable sources of radiation shall notify the Department within **ten (10) days** of such action. **THE ANNUAL FEE WILL CONTINUE TO BE ADDED TO YOUR REGISTRATION UNTIL THE DEPARTMENT IS NOTIFIED OF DISCONTINUANCE. THE FEE WILL NOT BE WAIVED IF THE DEPARTMENT HAS NOT BEEN NOTIFIED.**

Remove the following x-ray units:

Room Location of Unit	Machine Use Code	Control Panel Manufacturer	Control Panel Model Name and Number	Control Panel Serial No.	No. of Tubes

The unit(s) have been placed in storage and are not being used. The Department will be notified if this status changes.

An Arkansas registered vendor removed and took possession of the unit(s).

The unit(s) have been properly deactivated to where the tube cannot be energized (e.g. power cord cut) and disposed

The unit(s) were sold or donated to the following:

Name: _____ Phone Number: _____

Address: _____

Name:	Signature:
Title:	Date:



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Supplemental Sheet

Machine Use Code	Type of Unit
A	Analytical
BD	Bone Density
C	C-Arm
CH	Chiropractic
CR	Cabinet Radiography
CT	Computed Tomography (includes CBCT units)
CU	College/University (used for training purposes)
D	Dental
F	Fluoroscopic
I	Industrial
M	Mobile
MA	Mammography
P	Podiatric
R	Radiographic
RF	Radiographic & Fluoroscopic Units (2 tubes)
S	Security Systems
T	Therapeutic Radiation Machines
V	Veterinary
O	Other units (those that are not listed above)