GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P Kemp, Govenor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW Atlanta, GA 30303-3159 404-656-4507 www.dch.ga.gov

APPLICATION FOR X-RAY REGISTRATION

A. Facility Name (*DBA*)_____ Applicant_____

Address:_____Mailing Address: _____

City:_____State_____Zip_____ _

County:_____Telephone ( )_____Email: _____

B. Registration type (**check all that apply**):

☐ A new Facility
☐ A purchase of new equipment
☐ Relocation
☐ Update of information of previously registered facility
[ ] Other _____

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

_____ 1 Dental Intraoral
_____2 Dental Cephalometric
_____3 Dental Panographic
_____4 CBCT (Cone Beam CT)
_____5 Radiographic
_____6 R & F Same Unit No of tubes __
_____7 Mammography
_____8 C-Arm
_____9 Other_____
_____10 Bone Densitometer
_____11 X-ray Therapeutic
_____12 Therapeutic Accelerator
_____13 Particle Analyzer
_____14 Analytical
_____15 Cabinet X-ray
_____16 Open Beam X-ray
_____17 Computerized Tomography

D. Please Check one in each Category:

1. Practice

☐ 1 Medical
☐ 2 Dental
☐ 3 Chiropractic
☐ 4 Osteopathy
☐ 5 Veterinary
☐ 6 Podiatry
☐ 7 Industrial
☐ 8 Research
☐ 9 Institution
☐ 10 Other (Specify)

2. Facility Category

☐ 1 Private Office
☐ 2 Hospital
☐ 3 Clinic
☐ 4 Mobile
☐ 5 Education
☐ 6 Industrial
☐ 7 Institutional
☐ 8 Specify _____

E. List all x-ray machines at the facility or in mobile van. Attach sheet for additional machine(s)

Manufacturer_____ Model No._____ Serial No. _____

F. X-ray systems that have been disposed of: Manufacturer/Model/SN_____

G. For diagnostic facilities list at least one licensed practitioner(s) who will have the authority to prescribe x-rays. Please print.

_____

H. Signature of responsible individual authorized by the facility to include one of the following: a licensed practitioner, owner, administrator; and or radiation safety officer (as in nonmedical, industrial or hospital installations).

DCH Use Only

_____
Applicant/Authorized Signature and Title

_____
Print or type name

Date _____

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a **license, permit or registration**, as referenced in O.C.G.A. § 50-36-1, from the **Department of Community Health, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1) ☐ I am a United States citizen.

2) ☐ I am a legal permanent resident of the United States.

3) ☐ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as: _____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in_____(city),_____ (state).

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___DAY OF_____, 20____

_____
NOTARY PUBLIC
My Commission Expires:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HEALTHCARE FACILITY REGULATION DIVISION

NEW APPLICATION AND INITIAL LICENSE PAYMENT COUPON

Select the type of facility for which you are renewing. The dollar amount after the comma is the annual license fee.	X-ray Facility, $300 (one $300 initial activity fee covers all x-ray machines in use at the same business address):
Enter Contact Information	First Name: Last Name: Phone Number: Email:
Enter Facility Name	
Enter Physical Facility Address	Address 1: Address 2: City: State: GA Zip: -
Total Fee Owed	**Application Fee $0 + $300 Total Fee Due**
Amount of the Enclosed Check	

1. Complete and print this license payment coupon.

2. Write your check for the total fee due and make it payable to:
   Department of Community Health

3. Mail your check and this license payment coupon to:
   Department of Community Health
   PO Box 734653
   Dallas, TX 75373-4653

DO NOT MAIL PROVIDER APPLICATIONS OR OTHER CORRESPONDENCE TO THE ABOVE P.O. BOX!

Your application form and other correspondence should be sent to the address referenced in your application packet.