GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, M.D., Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

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.dch.georgia.gov
___ 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.

PERSONAL IDENTIFICATION REQUIREMENTS

All applications 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.

The application, shielding design and affidavit **must be mailed together**. Please do not fax. This will delay the registration process.

Please mail the original to:

Department of Community Health
Healthcare Facility Regulation Division
Health Care Section – Diagnostic Services
2 Peachtree Street, NW, Suite 31-447
Atlanta, GA 30303-3142
Attention: **X-ray Unit**

FACILITY: _____ COUNTY: _____

STATE OF GEORGIA	**)**	**AFFIDAVIT RE: PERSONAL**
	)	**IDENTIFICATION FOR**
COUNTY OF _____	**)**	**LICENSURE / REGISTRATION**

PERSONALLY APPEARED before the undersigned officer, duly authorized to administer oaths, came the undersigned, who after having been duly sworn, states under oath**,** the following:

1. That my name is_____ and that I am who I say I am;
2. That my address is_____;
3. That I have presented sufficient personal identification to the notary that is true and accurate;
4. That I am legally in the United States of America;
5. That I am applying to the Georgia Department of Community Health, Healthcare Facility Regulation Division, to operate a business/activity that is subject to regulation by the Department of Community Health; and that this affidavit is a material part of the application; and
6. That if the Department subsequently determines that the material information contained in this affidavit is false, I will be in violation of licensing/registration requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me

This _____ day of _____, _____.	**)**	
	)	
	)	
	)	_____
	)	**Affiant**
_____	**)**	
NOTARY PUBLIC	**)**	
STATE OF GEORGIA	**)**	

My commission expires: _____.

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 1-179])
- School identification card with 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

Source: http://www.uscis.gov/files/form/m-274.pdf US Handbook for Employers, page 23.

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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)

[ ] A new facility
[ ] A purchase of new equipment
[ ] Relocation
[ ] Update information of Previously registered
[ ] Other _____

Have you previously registered an X-ray Facility in Georgia? [ ] Yes [ ] No
If yes, under what name: _____
_____
and in what county: _____

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

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

E. 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 (see F below)
[ ] 5 Education
[ ] 6 Industrial
[ ] 7 Institutional
[ ] 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. Install 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)

_____
Authorized Signature/Title

_____
Print or Type Name

Date: _____

FOR DCH USE ONLY

Registration Number:

_____

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DIAGNOSTIC SERVICES UNIT
APPLICATION FOR REGISTRATION OF LASER FACILITY

CONTACT PERSON: _____ **PHONE:** _____
(Type or Print)

NAME OF FACILITY: _____

ADDRESS OF FACILITY: _____
(Street)

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

Type of Facility (Check)

1. _____Arts
2. _____Commercial
3. _____Construction
4. ___ Healing Arts
5. ___ Industrial
6. _____Institutional
7. _____School
8. _____Other _____

Type of Use (Check)

A. _____Alignment
B. _____Communication
C. _____Copying
D. _____Demonstration
E.___ Experimental
F. _____Forensic
G._____ Instructional
H. _____Healing Arts
I. _____Readers
J. _____Research
K. _____Other _____

<u>System Information</u>: **Laser or Laser Product**

Brand_____ Model_____

Lasing Medium_____ Certification Class_____

Pulsed_____ **or** C.W._____

Scanning_____ **or** Non-Scanning_____

Maximum Power Output _____ W or J

<u>Brief Description of Use</u>:

_____
Authorization Signature / Title

_____
(Print or Type)

_____
Date

Equal Opportunity Employer

Revised 3/17/2010

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 Non-controlled Area.

The areas outside the x-ray room are either controlled access areas or non-controlled 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.

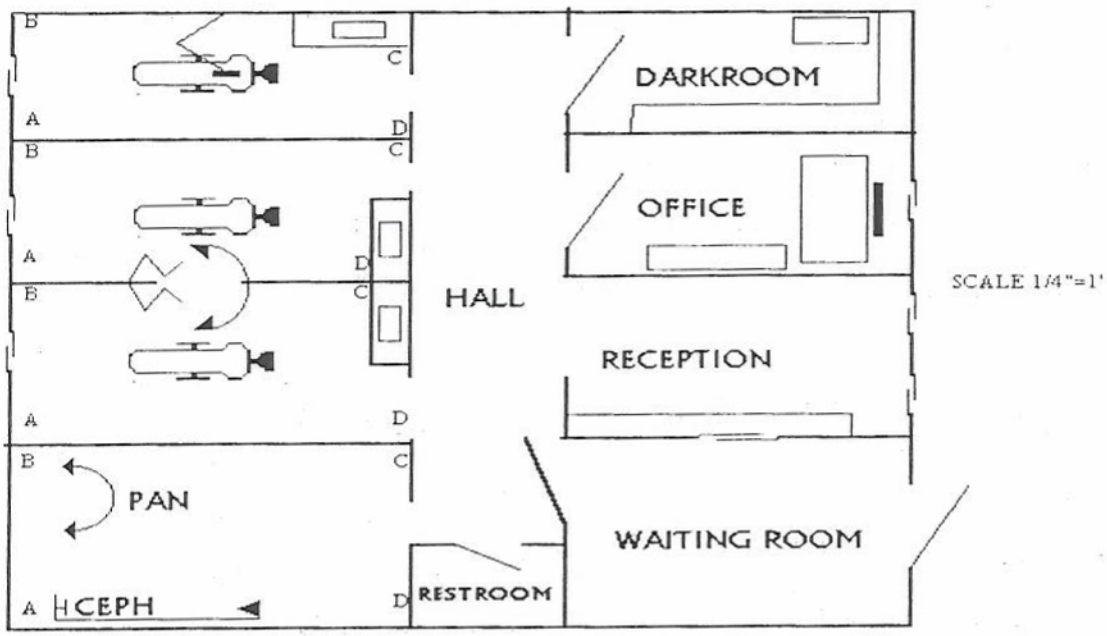
Any space not meeting the definition of a controlled area is a non-controlled area.

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

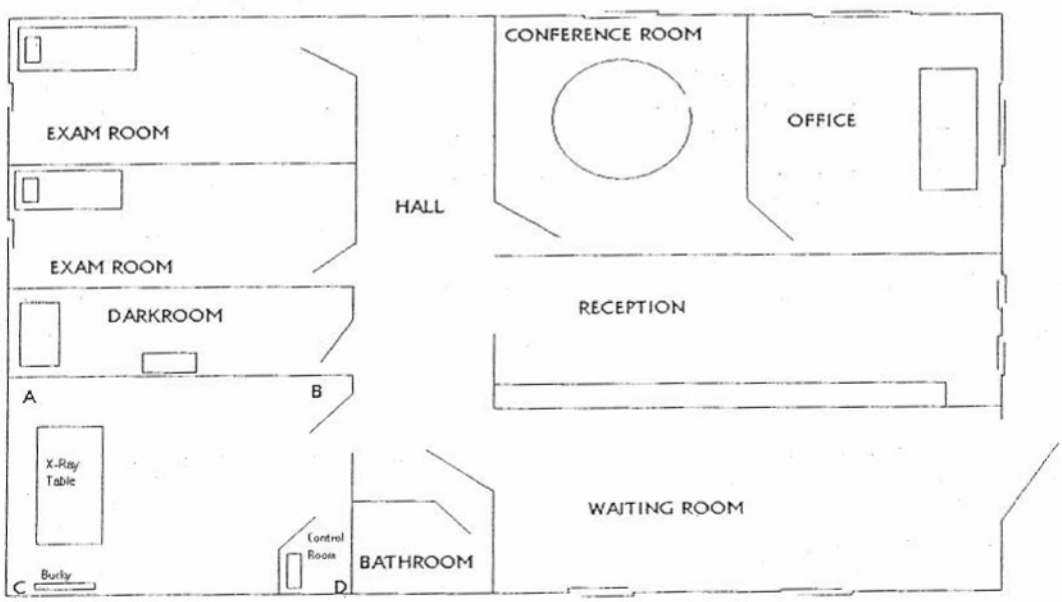
In order for Department staff to evaluate your shielding design, the construction materials and thicknesses of these materials at each barrier must be known. Be sure to include windows and doors.

As an example - for wall AB in our sample x-ray room there are two sheets of dry wall, each 2 inches thick. (**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 147.



SAMPLE DENTAL



Sample Medical

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
NMALLY 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					

REVISED 1/97

LIST OF QUALIFIED INDIVIDUALS AND HEALTH PHYSICISTS

This is an incomplete list.
Also check community colleges and x-ray suppliers and repair engineers.
The Healthcare Facility Regulation Division does not recommend or support any individual, company or organization.

Keep all documentation of training.

Mary Waldron, MS 2758 Terrell Trace Drive Marietta, GA 30067 Home / Fax 770-952-3053 Cell: 678-773-2813	Bill Ramsay Medical X-Ray Imaging 4875 Fowler Drive Cumming, GA 30041-8917 770-918-7550
Rose McTee Phoenix Technology 555 Sun Valley Dr. E-3 Roswell, GA 30076 770-645-1440 Fax: 770-645-1441	Jerry Allison August, GA Cell: 706-799-5389 Home: 706-736-7422
Daniel Staton, Ph, Certified Radiological Physicist Physic Imaging, LLC P.O. Box 660462 Birmingham, AL 35266 205-979-6999 Cell: 205-612-8127	Thomas G. Ruckdeschel, M.S. President Certified Alliance Physics Radiological Physicist 502 Abbey Court Alpharetta, GA 30004 770-751-9707 770-753-4305
Kerry Maughon Imaging Physics P.O. Box 545 Winder, GA 30680 Cell: 678-227-1255 Fax: 770-868-0607	Interstate Health Physics Consulting Bruce Gossett 139 Hunters Ridge Drive Lexington, SC 29072 803-356-4245
West Physics Consultants Geoffrey West 1-866-275-9378 geoff@westphysics.com	Patrick Booton 222 Wiley Bottom Rd. Savannah, GA 31411 912-350-8000 Fax: 912-598-0919
Ed Rocker Access Diagnostic Physics Cell: 770-842-7016 ed@accessphysics.com	Scott Sheilds Cell: 678-778-1084

Depending on the type of X-ray machine, the following initial X-ray Inspection Form(s) should be completed by the qualified individual.

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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:_____-_____

1. Have there been any changes in ownership? YES___ NO__ If yes, provide the date of change_____

   Who is 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 an area monitor for the full body? YES___NO___

4. Do you have lead apron(s) available? YES___NO___

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 an initial inspection /survey done by a qualified individual? YES___ If yes, what date? _____NO___ N/A_____

   (b) Does the facility have the qualified individual's credentials on file? YES___ NO____

9. 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 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_____

Return this form to DCH – HFRD Diagnostic Services Unit

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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2 Peachtree Street, NW
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www.dch.georgia.gov

DENTAL
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, provide the date of change:_____

   Who is the previous owner?_____

2. Does the x-ray tube head maintain its position during radiographic exposure? YES___ NO___ N/A ____
3. Are the open ended shielded cones the appropriate length 4" for 50KVP and less, 7" for KVP's greater than 50? YES__ NO__
4. Is 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 the 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___ If yes, what date?_____ NO___ N/A___
    (b) Does the facility have the qualified individual's credentials on file? YES___NO___
13. Is a copy of the qualified individual's 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_____

Return this form to DCH – HFRD Diagnostic Services Unit

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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, provide the date of change:_____

   Who is the previous owner? _____

2. Is the 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___

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 for use by person(s) in this 5mR/hr area? YES___NO___

8. Does this 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___ If yes, what date? _____NO___ N/A___
    (b) Does the facility have the qualified individual's credential on file? YES___ NO___

11. Is a copy of the qualified individual's 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_____

Return this form to DCH – HFRD Diagnostic Services Unit

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Revised 3/17/2010

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Atlanta, GA 30303-3159
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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, provide the date of change: _____

   Who is 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___

4. Does the safelight meet the film manufacturer's requirements?:
   (a) Correct wattage YES___NO___ (b) the filter YES___NO___

5. Is there a record of chemicals changed within a two 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 hours of mandatory radiation safety training and 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___ If yes, what date?_____ NO___ N/A___
    (b) Does the facility have the qualified individual's credentials on file? YES___NO___

11. Is a copy of the qualified individual's credentials enclosed with this questionnaire? YES___ NO___

12. Is there a warning statement on the control panel? 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, provide the date of change:_____

   Who is 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 light tight? YES___NO___

5. Are the chemicals changed within a two month period and a permanent record maintained of change? 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___

10. Does the machine have a warning statement? YES___ NO___

11. (a) Was an initial inspection/survey done by a qualified individual? YES___ If yes, what date?_____ 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 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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MAIL ALL STATE X-RAY APPLICATIONS TO:

Diagnostic Services Unit
Health Care Section
Healthcare Facility Regulation Division
Department Of Community Health
2 Peachtree Street, N.W.
Suite 31-447
Atlanta, GA 30303-3142

ATTN: X-RAY PROGRAM

Because faxed copies may not be clear and may distort your information we ask that all original paperwork be mailed to the above address.

After we have reviewed your application,
if we request additional documentation, you may fax any additions/changes and or supporting documents to:

(404)657–5442

Contact Personnel:

Sheela E. Puthumana BS MT (ASCP)
Program Manager
Phone: (404) 657-5447

Dinella Sears
Program Assistant
Phone: (404) 657-5400
Fax: (404) 657-5442

Revised: 02/15/2010 11:54 AM