



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** <http://dch.georgia.gov/>
- _____ 2. Shielding Design Format Requirements with example
- _____ 3. Reportable Incidents Instruction
- _____ 4. Initial Inspection Report

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**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

INSTRUCTIONS FOR COMPLETING AFFIDAVIT REQUIRED TO BECOME LICENSED

In order to obtain a license from the Department of Community Health to operate your business, Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that you are lawfully present in the United States of America. This affidavit is a material part of your application and must be completed truthfully. Your application for licensure may be denied or your license may be revoked by the Department if it determines that you have made a material misstatement of fact in connection with your application to become licensed. If a corporation will be serving as the governing body of the licensed business, the individual who signs the application on behalf of the corporation is required to complete the affidavit. Please follow the instructions listed below.

- 1. Review the list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your identity, such as a U.S. driver's license or a U.S. passport. Locate one original document on the list to bring to the Notary Public to establish your identity.**
- 2. Print out the affidavit. (If you do not have access to a printer, you can go to your local library or an office supply store to print out the document for a small fee.)**
- 3. Fill in the blanks on the Affidavit above the signature line only—BUT DO NOT SIGN THE AFFIDAVIT at this time. (You will sign the affidavit in front of the Notary Public.) Fill in the name of the secure and verifiable document (for example, Georgia driver's license, U.S. passport) that you will be presenting to the Notary Public as proof of your identity. CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:
 - **Option 1) is to be initialed by you if you are a United States citizen; or**
 - **Option 2) is to be initialed by you if you are a legal permanent resident of the United States. You are not a U.S. citizen but you have a green card; or**
 - **Option 3) is to be initialed by you if you are a qualified alien or non-immigrant (but not a U.S. citizen or a legal permanent resident) with an alien number issued by the Department of Homeland Security or other federal immigration agency. Fill in the alien number, as well.****
- 4. Find a Notary Public in your area. Check the yellow pages, the internet or with a local business, such as a bank.**
- 5. Bring your affidavit and the identification you selected (from the list of Secure and Verifiable Documents) to appear before the Notary Public.**

- 6. Show the Notary Public your secure and verifiable identification (anything on List that follows these instructions) and state under oath in the presence of the Notary Public that you are who you say you are and that you are in the United States lawfully. Then sign your name.**
- 7. Make certain that the Notary Public signs and dates the affidavit and puts when the notary commission expires.**
- 8. Make a copy of the affidavit and the identification that you presented to the Notary Public for your own records.**
- 9. Attach the ORIGINAL SIGNED AFFIDAVIT and a copy of the identification you presented to your application for licensure. DO NOT SEND US YOUR AFFIDAVIT SEPARATELY. IT MUST BE INCLUDED IN THE COMPLETE APPLICATION PACKET WHICH YOU MAIL TO US.**

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:



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

APPLICATION FOR X-RAY REGISTRATION

A. Applicant: (Please Print or Type) Facility

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) 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, 19 Bone Densitometer Other

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)

FOR DCH USE ONLY Registration Number:

Authorized Signature/Title Print or Type Name Date:



DIAGNOSTIC SERVICES UNIT APPLICATION FOR REGISTRATION OF A LASER FACILITY

CONTACT PERSON: (Type or Print) PHONE

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

System Information Laser or Laser Product

Brand Model Lasing Medium Certification Class Pulsed or C.W. Scanning or Non Scanning Maximum Power Output W or J

Brief Description of Use

Authorizations Signature / Title (Print or Type) 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 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.

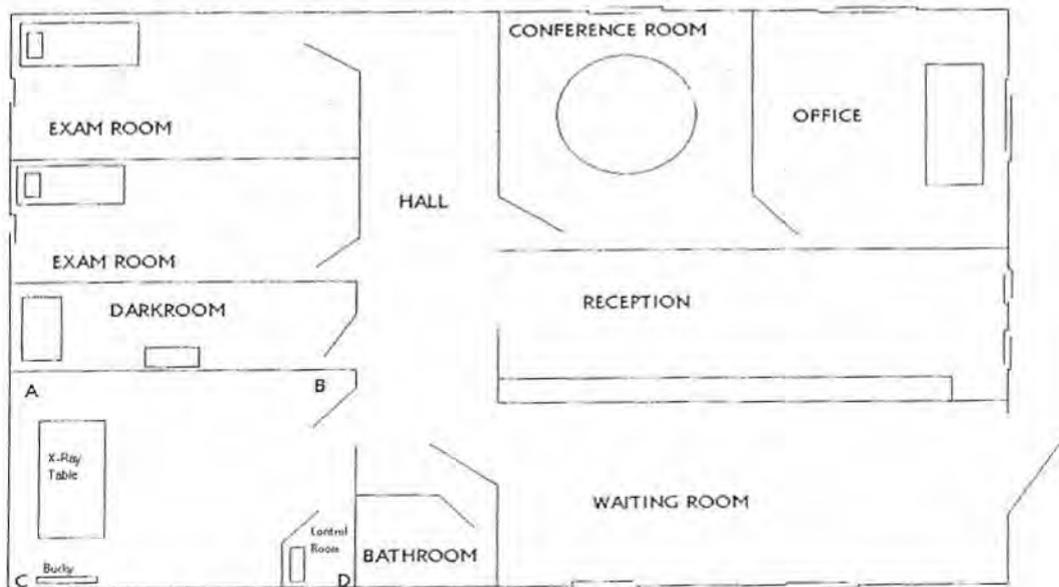
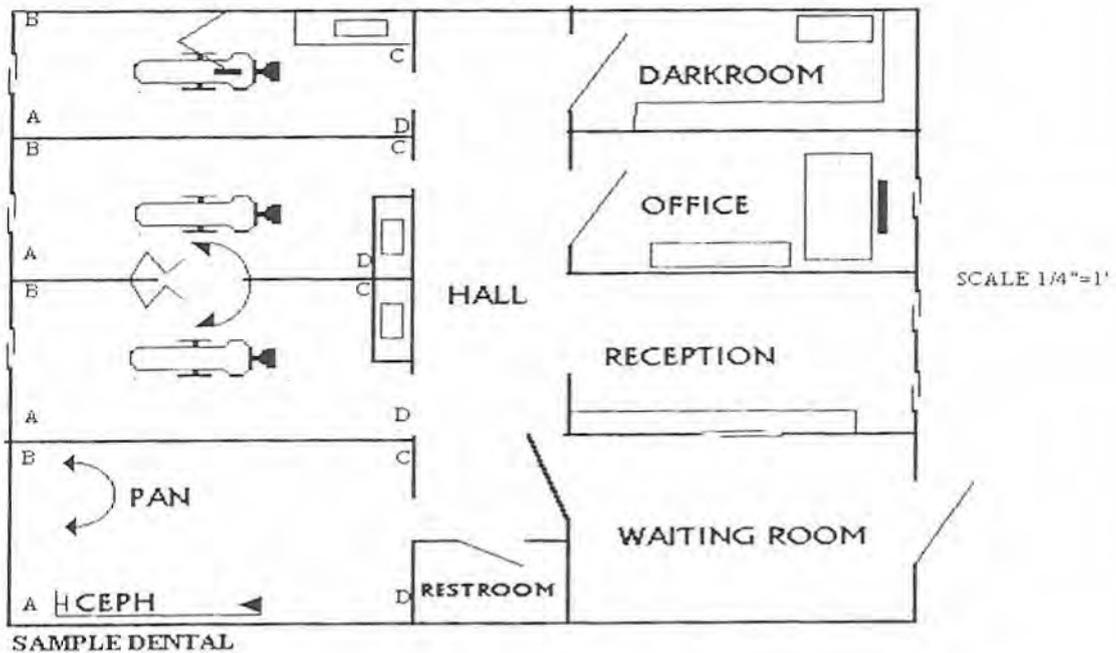
(10.) Column 6. Construction Material and Thickness.

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.



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					



LIST OF HEALTH PHYSICISTS AND QUALIFIED INDIVIDUALS

This is an incomplete list.

Also check community colleges and x-ray suppliers and repair engineers.
Whenever you schedule training be sure to check around for the best cost and the best qualifications of the instructor. Make sure that what is being taught is at least what is required by the State of Georgia as listed in the Rules and Regulations of the X-Ray chapter 290-5-22.

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

Daniel Staton, Ph, Certified Radiological
Physicist
Physic Imaging, LLC
P.O. Box 660462
Birmingham, AL 35266
205-979-6999
205-612-8127 cell

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

Thomas G. Ruckdeschel, M.S., President
Certified
Alliance Physics
Radiological Physicist
502 Abbey Court
Alpharetta, GA 30004
770-751-9707
770-753-4305

Patrick Booton
222 Wiley Bottom Rd.
Savannah, GA 31411
912-350-8000
Fax 912-598-0919

Scott Sheilds
Cell 678 – 778 - 1084

Ed Rocker
Access Diagnostic Physics
Cell 770-842-7016
ed@accessphysics.com

Jerry Allison
August, GA
Cell 706-799-5389
Home 706-736-7422

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



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) (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 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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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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) (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" if greater than 50? YES ___ NO ___
4. Is the operator able to stand a minimum of 6 ft 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 2 month period and a permanent record maintained? YES ___ NO ___ N/A ___
8. Is the darkroom light tight? 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 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 report enclosed with this questionnaire? YES ___ NO ___
14. (a) Do the operator(s) have the 6 hrs 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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NON-MEDICAL 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)

(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 the 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 ___
10. (a) Was an initial inspection 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 report enclosed with this questionnaire? YES ___ NO ___
12. (a) Do the 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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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)

(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) Do the operator(s) have the 6 hrs 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 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 report 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)

(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 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 2 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. (a) Does the operator(s) have the 6 hrs of 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 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

Return this form to DCH - HFRD Diagnostic Services Unit



MAIL ALL STATE X-RAY APPLICATIONS TO:

Department Of Community Health
Healthcare Facility Regulation Division
Diagnostic Services Unit
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:

Nancy Spradlin
Program Director
Phone: (404) 657-5447

Barbara Belcore
Surveyor Specialist
Phone: (404) 657-5400

Instructions for Completing the X-RAY Self-Report Form
State of Georgia
Healthcare Facility Regulation Division
Health Care Section
Diagnostic Services Unit
CHAPTER 290-5-22-.07 (2) & (4)

Reportable Incidents

This form is designed for notifying the Health Care Facility Regulation Division (HFRD) 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 HFRD of such incidents is NOT required.

Directions for completing the X-RAY Incident Reporting 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 is one event; high count film badges of unknown exposure origin are a 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 found on your facility license/certificate. The contact person(s) listed will be the person(s) HFRD 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 HFRD, 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 patients'."

Immediate Corrective or Preventive 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: in-service & 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.



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

X-RAY INCIDENT REPORTING FORM (Please type form)

FACILITY INFORMATION

Name of Facility: Facility Type: X-Ray Registrant #: Address: City: State: Zip Code: Person Reporting Incident: Title: Contact Person(s): Contact Phone #: Fax #: Email Address:

PATIENT / REPORTING INFORMATION

Date: Time: a.m. /p.m. Reported to Healthcare Facility Regulation Division Date: Time: a.m. /p.m. Facility Was Aware of the Incident Date: Time: a.m. /p.m. Incident Occurred

Affected Patient or Employee Name Age Sex Date of Birth

Patient Med Rec # (as applicable) Date of Admission

Patient's Diagnosis

TYPE OF INCIDENT: Please check appropriate boxes. (Attach a copy of incident report if applicable)

- [] Over exposure of the whole body to 5 rems or more [] Over exposure of the whole body to 25 rems or more [] Over exposure of the skin of the whole body to 30 rems or more [] Over exposure of the skin of the whole body to 150 rems or more [] Over exposure of the feet, ankles, hands or forearms to 75 rems or more [] Over exposure of the feet, ankles, hands or forearms to 375 rems or more [] Exposure of an individual to radiation in excess of any applicable limit set forth in the rules [] Levels of radiation in an uncontrolled area in excess of 10 times any applicable limit set forth in the rules

