



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

David A. Cook, Commissioner

Nathan Deal, 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**

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:



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

E. Please check one in each category:

1. Practice

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

2. Facility Category

- ☐ 1 Private Office ☐ 5 Education
☐ 2 Hospital ☐ 6 Industrial
☐ 3 Clinic ☐ 7 Institutional
☐ 4 Mobile (see F below) ☐ 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: _____



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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

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:

Authorization 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.

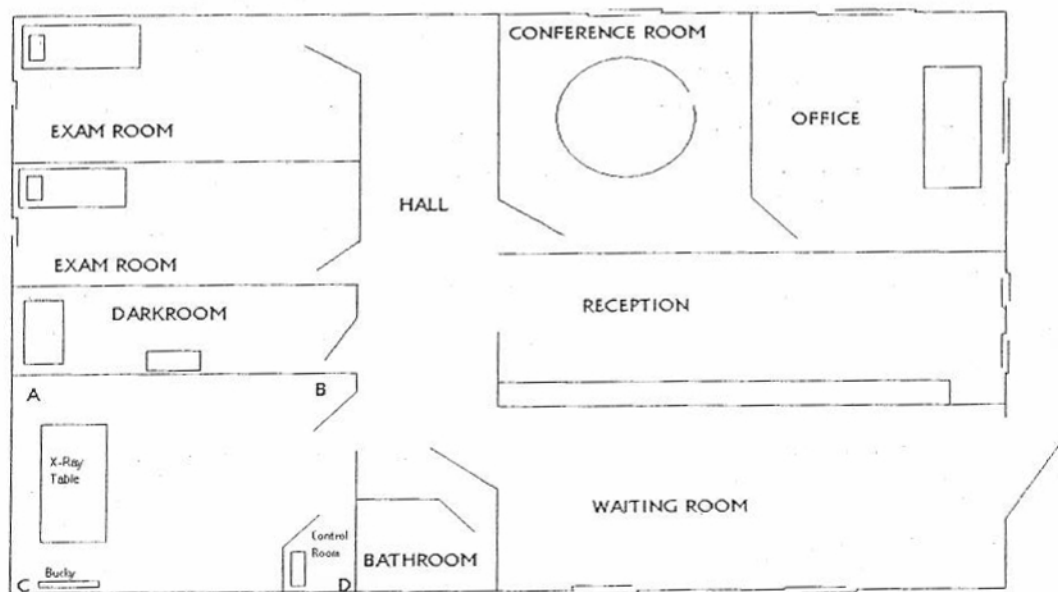
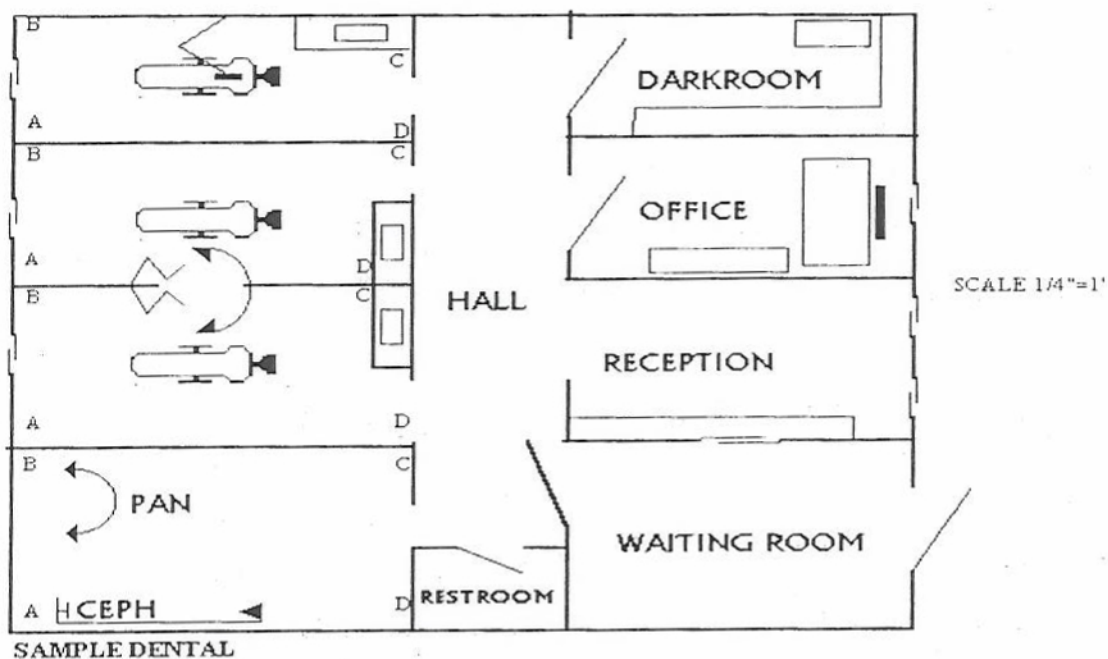
(10.) Column 6. Construction Material and Thickness.

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					
WALL					
WALL					
WALL					

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

Equal Opportunity Employer



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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 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 _____

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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 _____

Return this form to DCH – HFRD Diagnostic Services Unit

Equal Opportunity Employer



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

David A. Cook, Commissioner

Nathan Deal, Governor

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

**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 _____

Return this form to DCH – HFRD Diagnostic Services Unit

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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

Equal Opportunity Employer

Instructions for Completing the Xray Self Reporting Form

Reportable Incidents

This form is designed for notifying the Healthcare 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 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 Preventative 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: inservice & 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.



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

David A. Cook, Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
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): _____ Phone No. of Contact: _____

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 _____

Social Security Number _____ Patient Med Rec # (as applicable) _____

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

Briefly describe circumstances of the incident: (Attach additional sheet if necessary)

CATEGORY OF STAFF INVOLVED IN THE INCIDENT (Check all that apply)

☐ Radiologist ☐ Radiological Technician ☐ Other (Specify)_____

Immediate Corrective or Preventative Action Taken: (attach additional sheet if necessary)

Note: If the incident involved a death, was the medical examiner notified? ☐ YES ☐ NO ☐ N/A

Was an autopsy requested? ☐ YES ☐ NO

Name and contact number of Medical Examiner_____

Acknowledgement of Information Reported:

I attest that the information reported within this form is true and accurate and completed to the best of my knowledge.

Signature of Person Completing Form

Title

Date Completed

Print Name

For Department Use Only

Received in S/A Date:_____

Reviewed By: _____ Date:_____

Reporting time frame met? () Yes () No

Action Required? () Yes () No

Self Report ID# _____ Complaint Number_____

This report is required as set forth in the X-ray Rules §290-5-22-07 (2) and (4).