

**IOWA DEPARTMENT OF PUBLIC HEALTH, BUREAU OF RADIOLOGICAL HEALTH**

**LUCAS STATE OFFICE BUILDING, 5TH FLOOR, 321 EAST 12TH STREET, DES MOINES, IOWA 50319**

**APPLICATION FOR Vet RAD/FLUORO (2 tubes), FLUORO, C-ARM EQUIPMENT**

Complete the following application by typing your information into the fields and print the form. Or you may print the application and handwrite the information. Or you may complete the application online (if available for the program). Please include all required copies of additional information requested. Send the completed form and the nonrefundable fees indicated below in a check or money order made payable to: Iowa Department of Public Health, Bureau of Radiological Health Lucas State Office Building, 5th Floor, 321 E 12th Street, Des Moines, IA 50319

\*Please attach each Equipment application to the Facility Application Form (Use additional pages for more Equipment if necessary.)

If you have any questions, please contact:

Charlene Craig Phone: 515-281-0415 Email: charlene.craig@idph.iowa.gov

**FACILITY INFORMATION:**

Facility Name: \* \_\_\_\_\_

Street Address: \* \_\_\_\_\_

City: \* \_\_\_\_\_ State: \* \_\_\_\_\_ Zip: \* \_\_\_\_\_

Permit Number: \* \_\_\_\_\_ Phone Number \*: \_\_\_\_\_

Email: \_\_\_\_\_ EIN/SSN: \* \_\_\_\_\_

**VET EQUIPMENT FEE DETAILS:**

VET Equipment	PER EQUIPMENT FEE \$	Number of each type of Vet Equipment	Total amount due for Vet (RAD/FLUORO (2 tubes), FLUORO, C-arm EQUIPMENT only)
Fluoro	25	_____	\$_____
C-arm	25	_____	\$_____
Rad/Fluoro (2 tubes)	50	_____	\$_____

**VET EQUIPMENT TYPE (Check One):**

**C-ARM**

**FLUORO**

**RAD/FLUORO (2 tubes)**

**C-ARM, FLUORO, RAD/ FLUORO (2 tubes) EQUIPMENT INFORMATION:**

Is this unit a Mobile Unit?	Yes	No	N/A
Is this unit used outside of your facility?	Yes	No	N/A
Machine Manufacturer	_____		
Machine Model	_____		
Machine Serial #	_____		
Date of Manufacture	_____		
Installation Date	_____		
Room ID Number	_____		
Service Provider-Company Name	_____		
Service Provider-Registration Number	_____		
Date of most recent calibration/service evaluation report	_____		
All fluoroscopic procedures are supervised by an individual who meets the requirements in IAC 641-41.1(6) n	Yes	No	
Leaded aprons and gloves and/or portable shields are available for use during fluoroscopy procedures.	Yes	No	
Facility has process to maintain records of cumulative fluoroscopic exposure time used and the number of spot films for each examination.	Yes	No	

**MOBILE SITES (If Applicable):**

Site Name	_____
Address, City, State, Zip	_____
Typical Schedule	_____
Equipment Description	_____

Site Name	_____
Address, City, State, Zip	_____
Typical Schedule	_____
Equipment Description	_____

I am authorized to complete this application on behalf of the organization.

As representative of the organization, I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. As said representative of the organization, I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning this application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that a representative of the organization is responsible to update information submitted herewith if the response or the information changes.

In submitting this application, the organization agrees to any reasonable inquiry that may be necessary to verify or clarify the information provided on or in conjunction with this application.

I understand this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this license, permit, registration, or certification and will make employees aware as required and will comply with those provisions

\_\_\_\_\_  
Signature of Organizational Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name of Organizational Representative

\_\_\_\_\_  
Date