Iowa Department of Public Health, Bureau of Radiological Health

Registration for Dental Radiation Machines

***Mailing Address*:**

Iowa Department of Public Health
Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street
Des Moines, IA 50319

Send the following to the Mailing Address given:

- Your completed registration.
- A ***nonrefundable fee*** in a check or money order payable to: **Iowa Department of Public Health.**
- Your completed equipment information.
- The date(s) of your last equipment calibration.

Questions?

Customer Support Phone: 855-824-4357 Email: adperehreg@idph.iowa.gov

Internet Address: https://idph.iowa.gov/regulatory-programs/radiation-machines

FACILITY INFORMATION: *(Type or print the information below)* ☐ This is a new address.

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Registration Number DENT _____

Email: Required _____ EIN/SSN: _____

Facility Contact Person: _____

Select Registration(s): Your renewal application should be submitted approximately **45 days before** your permit expires.

*(Mark your selection below for **your type of registration**) Maximum Fee for Dental is $3000*

IF YOUR REGISTRATION IS 30 DAYS PAST DUE, PLEASE ADD $25 A MONTH LATE FEE TO THE TOTAL DUE LATE FEE = $ _____

Intraoral
☐ $60 x Units = $ Total

Panoramic/Cephalometric
☐ $60 x Units = $ Total

Total Units = Unit Total

Cone Beam CT
☐ $60 x Units = $ Total

Hand Held
☐ $60 x Units = $ Total

Total Due = $ Total

Affirmation Questions: (REQUIRED)

(New) Has...
(Renewal) During the previous licensing period, did…
…any state or other jurisdiction of the United States or any other nation limit, restrict, warn, censure, place on probation, suspend, revoke, or otherwise discipline a professional license, permit, registration, or certification issued to you or the organization? ☐ Yes ☐ No

If yes, include the date, location, reason, and resolution.

_____

(New) Have...
(Renewal) During the previous licensing period, did…
…you or the organization had/have a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body? ☐ Yes ☐ No

If yes, provide a description of the circumstances.

_____

(New) Have there ever been...
(Renewal) During the previous licensing period, were there…
…judgments or settlements paid on your or the organization's behalf as a result of a professional liability case? ☐ Yes ☐ No

If yes, include the date, location, reason, and resolution.

_____

Facility Details: (REQUIRED)

Do you have a Radiation Protection Program that meets the parameters as outlined in IDPH guidance?	☐ Yes	☐ No
Is the licensed practitioner the only operator?	☐ Yes	☐ No
Is dosimetry issued to operators? If yes, Dosimetry Vendor name:_____	☐ Yes	☐ No
If no dosimetry is issued, I have documentation from a medical physicist or other personnel qualified to make the determination that no staff will exceed 10% of the annual 5 rem dose limit.	☐ Yes	☐ No
This facility has been previously registered to use radiation emitting equipment.	☐ Yes	☐ No
All radiation equipment operators are trained in safe operating procedures and are competent in the safe use of the radiation machine.	☐ Yes	☐ No
The facility has a method to log all x-ray exposures with the required information.	☐ Yes	☐ No
The facility will periodically review the exposure log for repeat trends and reinstruct staff accordingly.	☐ Yes	☐ No
Leaded aprons and gloves are available for use during x-ray procedures.	☐ Yes	☐ No
Are facility familiar with Image Gently / Image Wisely campaign advisements specific to the types of equipment your facility operates?	☐ Yes	☐ No

EQUIPMENT INFORMATION:

Mark the box(es) and fill in your equipment information below. If you are including copies of your most recent calibration reports and the information on the reports is accurate, you do not need to complete this section.

☐ Intraoral ☐ Panoramic/Cephalometric ☐ Cone Beam CT ☐ Hand Held

Is this a Mobile Unit? ☐ Yes ☐ No	Is this unit used outside your facility? ☐ Yes ☐ No
Machine Manufacture	Machine Serial #
Machine Model	Room ID
Manufacture Date	Installation Date
Date of current calibration or service evaluation report	

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DUPLICATE THIS PAGE AS NEEDED

MOBILE SITE INFORMATION: *(Complete only if you have mobile equipment used **outside** of the registered facility.)*

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

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Address, City, State, Zip
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Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a) (13) and Iowa Code § 252J.8 (1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18. **NOTE:** This does not apply to facilities that have obtained an EIN, only to facilities under a Sole Proprietorship.

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 (REQUIRED) | Date

rev 12-Aug-20