

## Iowa Department of Public Health, Bureau of Radiological Health Registration for Medical or Chiropractic Radiation Machines

**Mailing Address:**

Send the following to the Mailing Address given:

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

- 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: [adpereg@idph.iowa.gov](mailto:adpereg@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 MED \_\_\_\_\_

Email: Required \_\_\_\_\_ EIN/SSN: \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_

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

(Mark your selection below for **your type of registration**) Maximum Fee for Medical/Chiro is \$3000

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

**RAD/Fluoro** (2 tubes)      **IR/Fluoro** (single plane)      **C-Arm**      **CT**  
 \$240 x Units = \$ Total     \$120 x Units = \$ Total     \$120 x Units = \$ Total     \$120 x Units = \$ Total

**X-Ray Mach/Fluoro** (1 tube)    **IR/Fluoro** (bi plane)      **Bone Densitometry**  
 \$120 x Units = \$ Total     \$240 x Units = \$ Total     \$55 x Units = \$ Total    **Total Due = \$** \_\_\_\_\_

**FLUORO QUESTIONS:** (Complete only if you have a fluoroscopy machine)

All fluoroscopic procedures are supervised by an individual who meets the requirements in IAC 641-41.1(6)n	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaded aprons and gloves and/or portable shields are available for use during fluoroscopy procedures.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Facility has a process to maintain records of cumulative fluoroscopic exposure time used and the number of spot films for each examination.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Equipment has a dose area product monitor capable of recording the total radiation dose received by the patient.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient doses are logged in the patient chart for each exam.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Processes in place to review adult doses exceeding 300 rad and child doses (under 18) exceeding 100 rad.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Affirmation Questions:** (REQUIRED)

**(New)** Has...

**(Renewal)** During the previous licensing period, did...  Yes  No  
...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?

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

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**(New)** Have...

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

If yes, provide a description of the circumstances.

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**(New)** Have there ever been...

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

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

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**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?  Yes  No

If yes, Dosimetry Vendor name: \_\_\_\_\_

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

The licensed practitioner is the only operator of this x-ray equipment.  Yes  No

All radiation equipment operators have an Iowa permit to operate the 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 and fill in the equipment information)

- RAD/Fluoro (2 tubes) 
  X-Ray Machine/Fluoro (1 tube) 
  IR/Fluoro (single plane)  
 IR/Fluoro (bi plane) 
  CT 
  C-Arm 
  Bone Densitometry

Is this a Mobile Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this unit used outside your facility? <input type="checkbox"/> Yes <input type="checkbox"/> 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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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.

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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 5-Feb-20