

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 DENTAL, MEDICAL-CHIRO, PODIATRY, OR VET RADIOLOGICAL FACILITY

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 East 12th Street, Des Moines, IA 50319

If you have any questions, please contact:

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

FACILITY INFORMATION: please print or type.

Facility Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip: * _____

Phone Number 1: * _____ Phone Number 2: _____

Email: _____ EIN/SSN: * _____

AFFIRMATION QUESTIONS:

Has any state or other jurisdiction of the United States or any other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or otherwise disciplined a professional license, permit, registration, or certification issued to you or the organization? * Yes No
If yes, include the date, location, reason, and resolution.

Have there ever been judgments or settlements paid on your behalf or on the organization's behalf as a result of a professional liability case? * Yes No
If yes, include the date, location, reason, and resolution.

Have you or the organization ever had 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.

FACILITY DETAILS:

Do you have a Radiation Protection Program that meets the parameters as outlined in IDPH guidance? * Yes No

Is dosimetry issued to staff* Yes No
 Dosimetry Vendor name

My staff will not be issued dosimetry. 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

Is facility familiar with Image Gently/Image Wisely campaign advisements specific to the types of equipment your facility operates? * Yes No

RECIPROCITY:

List the name, address, nature of use and dates of the locations in Iowa where this unit will be used.	
Name and permit number of diagnostic radiographers operating the unit(s) while in the state of Iowa.	
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FACILITY CONTACT LIST: List each Facility Contact Details separately. (Use additional pages if necessary)

CONTACT TYPES:

Bone Densitometry, CEO, Facility Contact, Medical Physicist, Podiatry, Radiologic Technologist (General Tech), Service Provider, Radiologic Technologist (Limited).

First Name: * _____ Last Name: * _____

Phone Number: * _____ Email: _____

License Number: _____ Business Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip Code: * _____

Comments: _____

CONTACT TYPES:

Bone Densitometry, CEO, Facility Contact, Medical Physicist, Podiatry, Radiologic Technologist (General Tech), Service Provider, Radiologic Technologist (Limited).

First Name: * _____ Last Name: * _____

Phone Number: * _____ Email: _____

License Number: _____ Business Name: * _____

Street Address: * _____

City: * _____ State: * _____ Zip Code: * _____

Comments: _____

EQUIPMENT FEE DETAILS:

Total Amount Due for all Equipment: \$ _____

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