*Reg. No.*_____

FORM 1R SUPPLEMENTAL
APPLICATION FOR RADIATION MACHINE FACILITY REGISTRATION

Facility Name:_____

Machine Type (code)	Make	Model	X-ray tube (T) or control (c) s/n	Location

I certify that the above information is correct. Changes will be reported in writing within ten (10) days to the address below.

Signature (required):_____ Date:_____

Print name: _____

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Bureau for Public Health
Office of Environmental Health Services
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