



WV DHHR Bureau for Public Health OEHS
Radiological Health Program
1 Davis Square, Suite 200
Charleston, WV 25301-1798

Reg. No. _____

Date _____

REGISTRATION OF RADIATION PRODUCING DEVICES: PARTICLE ACCELERATORS AND THERAPY

APPLICATION FOR REGISTRATION OF PARTICLE ACCELERATOR, ORTHOVOLTAGE OR OTHER TELE THERAPY MACHINES MUST BE SUBMITTED PRIOR TO OPERATION ON HUMANS, EXCEPT FOR EVALUATION AND TESTING, PURSUANT TO THE WV CODE OF STATE REGULATIONS: RADIOLOGICAL HEALTH RULES.

1.(a) Registrant Information:

 Name

 Address

 City State Zip Code

 Phone Number Fax

2. Machine registration type: (check category)

a. Therapy _____

b. Cyclotron _____

c. Amendment _____

d. Renewal _____

If c. or d. indicate current WV Registration Number _____

FID (Tax I.D.) _____

1.(b) Registrant is: An individual ()
 A partnership () A corporation ()
 Other ()

3. Other location of the machine: (* indicate if mobile)

 Address

 City State Zip Code

4. Radiation Producing Device Information

Location (Accel., Sim., Industrial)	A. Type of Unit MV	B. Peak kVp, MV	C. Mfr. and Model (electron / photon)	D. Type of Radiation Dose Rate (isocenter)	E. Maximum Dose Rate (isocenter)	F. Year of installation
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

(attach list of machines and locations if necessary)

5. The following information is attached and is part of this application (to be incorporated into the registration):

	Attached	Not Applicable*	Date Submitted
a. Overall description of radiation safety program.	_____	_____	_____
b. Description of facility	_____	_____	_____
(1) Architectural building and shielding plans	_____	_____	_____
(2) Diagram of radiation monitoring & safety systems	_____	_____	_____
c. Description of radiation detection instruments	_____	_____	_____
d. Instrument calibration procedure and frequency	_____	_____	_____
e. Personnel monitoring equipment and frequency	_____	_____	_____
f. Operating and emergency procedures	_____	_____	_____
g. Training program for occupational exposed workers	_____	_____	_____
h. Reporting misadministrations and management control	_____	_____	_____
i. Radiation safety committee / members	_____	_____	_____
j. Radiation Safety Officer (RSO)	_____	_____	_____
k. Training and experience of operators/users	_____	_____	_____
l. Training and experience of physicians, medical physicists (if healing arts) or other qualified experts	_____	_____	_____
m. Shielding survey (shielding plan or rad. protection survey)	_____	_____	_____

*State reason if not applicable.

(continued on page 2)



6.(a) Does the machine contain depleted uranium? **yes ____ / no ____

Subject to 64-CSR-23.11.4a General Registration	
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6.(b) Does the machine produce radioactive materials during operation of the machine? **yes ____ / no ____
[**if yes, explain a) isotope, b) physical form, c) maximum energy, d) shielding used, e) method of monitoring and f) alarm limits.]

Subject to 64-CSR-23.11.4b Specific Registration	
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7. Is the facility subject to the requirements of a registration for technically enhanced (TENORM) or accelerator produced radioactive material (NARM) ? yes __ / no __

8. Has any machine been installed or upgraded to a higher energy on or after July 1, 2001 ? yes __ / no __

9. If answer is "yes" to question 8 please include a Radiation Protection Survey completed by a qualified expert. {pursuant to conditions of 64-CSR-23.10.11}

10. Signature: *I certify that all information contained in this application including any supporting document is true and correct to the best of my knowledge.*

a. Chief Executive / Operating Officer (CEO or COO) for registrant named in 1(a)

Name (print)	Title	Signature	Date

b. Radiation Safety Officer (RSO) responsible for implementation of the overall radiation safety program (item 5.a)

Name (print)	Signature	Date

c. Medical Physicist and Authorized Users identified in item 5.k and 5.l

Name (print)	Signature	Date

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(attach additional signature pages, if necessary)

ATTACH PAYMENT OF REGISTRATION / RENEWAL FEE (\$120) Checks payable to: BPH, [__ check enclosed?]

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DATE APPLICATION FEE (\$120) RECEIVED Chief, Radiological Health Program Date