NYC DEPT OF HEALTH & MENTAL HYGIENE
Office of Radiological Health

Disposition of X-ray Equipment

INSTRUCTIONS: Print or type all information. Please sign (required) and return the completed form.

1. Facility Registration Number ☐☐☐☐☐☐☐☐

2. Facility Information

   Facility Name ______________________________

   Premise Address: ______________________________

3. Number and Type of Units

   A. ____ Dental/CBCT/Hand-held
   B. ____ Radiographic Fixed/Mobile
   C. ____ Fluoroscopic C-Arm Fixed/Mobile
   D. ____ Comb R&F
   E. ____ CT Scanner (includes PET/CT)
   F. ____ Bone Densitometer
   G. ____ Mammography
   H. ____ Stereotactic Breast Biopsy
   I. ____ Medical Accelerator/OBI
   J. ____ Therapy (0 KVP-1MV)
   K. ____ Non-Medical Electron Microscope
   L. ____ Non-Medical X-ray Diffraction
   M. ____ Non-Medical Particle Accelerator
   N. ____ Non-Medical Gauge or Screening
   O. ____ Non-Medical Industrial Radiography
   P. ____ Non-Medical XRF
   Q. ____ Other ______________________________

4. Current Status of Equipment:

   A. Are you closing your registration? ☐ YES ☐ NO

   B. Has equipment been sold? ☐ YES ☐ NO

      If yes, date of sale: ____ / ____ / ____ (Month Day Year)

   C. Has equipment been disassembled or scrapped? ☐ YES ☐ NO

      If yes, give date: ____ / ____ / ____ (Month Day Year)

   D. Is equipment currently in use? ☐ YES ☐ NO

      Date stop using equipment ____ / ____ / ____ (Month Day Year)

New location of equipment (if applicable) ______________________________

____

Phone (____) ____ - ____

Signature of operator or RSO ______________________________

Print Name ______________________________

Title ______________________________ Date ____________

Return by email to: ORH@health.nyc.gov or fax to 718.310.2888

Questions? Call 718.310.2840