**Form 2**

GOVERNMENT OF BERMUDA

Ministry of Health and Seniors

**Department of Health**

# Radiation Machine Registration

| | |
|---|---|
| Registration Number(s) (assigned by DOH) | Name of Person Responsible for Radiation Safety |
| Name of Facility (where equipment is located) | Name for Billing Purposes (if different) |
| Address of Facility | Billing Address (if different) |
| Name of Administrative Contact at Facility | Facility Telephone Number |

**A. Enter the NUMBER of radiation machines (X-RAY tube heads, radioisotopes…) in the applicable block(s).**

**1. Medical X-Rays and MRI**

- Radiographic ---------- ☐
- Fluoroscopic ---------- ☐
- Radiographic/Fluoro (one tube) ---------- ☐
- Mammographic ---------- ☐
- Bone Densitometer ---------- ☐
- CT Scanner ---------- ☐
- MRI ---------- ☐
- Therapy ---------- ☐
- Other (describe in C below) ---------- ☐

**2. Dental X-Rays**

- Intra-oral ---------- ☐
- Panoramic, Cephalometric, Combination ------- ☐

**3. Medical Accelerator** (describe in C below)

- Electron linear ---------- ☐

**4. Veterinary X-Rays** ---------- ☐

**6. Industrial/Educational X-Rays** (Non-human use)
*Industrial radiographers must submit copy of operating and safety procedures, training program, radiographer qualifications*

- Non-cabinet Radiographic ---------- ☐
- Non-cabinet Fluoroscopic ---------- ☐
- Diffraction ---------- ☐
- Spectrometry ---------- ☐
- Fluorescence ---------- ☐
- Gauge ---------- ☐
- Cabinet ---------- ☐
- Ion Implanter (< 1 MeV) ---------- ☐
- Baggage ---------- ☐
- Other (explain in comments) ---------- ☐

**7. Radioisotopes Industry, Education and Research** (Enclose list in C)

- Sealed Sources ---------- ☐
- Open Sources ---------- ☐
- Build in the equipment ---------- ☐

**5. Radioisotopes Medical** (Enclose List In C)

Sealed Sources ---------- ☐

Open Sources ---------- ☐

Build in the equipment ---------- ☐

**8. Electromagnetic Radiation In Communications**

Broadcast RF facility ---------- ☐

Open field RF heating devices ---------- ☐

**B. Enter Yes/No in the applicable block(s) below.**

| | |
|---|---|
| 1. Enclosed copy of the specifications of the machine --- ☐ | 4. Facility designed by an architect ---------- ☐ |
| 2. Licence Conditions received and accepted ---------- ☐ | 5. Facility drawings approved by Medical Physicist -------- ☐ |
| 3. Maintenance documentation available ---------- ☐ | 6. Quality Control and Safety Information available ------- ☐ |

**C. COMMENTS: Please use the following space to enter additional information requested on the front of this form**

**D. Radiation Equipment Information (use additional forms if necessary)**

1. Manufacturer's Name | Model Number | Serial Number | Date of Purchase

2. Manufacturer's Name | Model Number | Serial Number | Date of Purchase

3. Manufacturer's Name | Model Number | Serial Number | Date of Purchase

**E. Name or Address Change**

Report address change to Department of Health

**By the signature below, the registrant acknowledges this is an accurate record of the equipment and in their use.**

Signature | Title or Position

Print Name | Date

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