NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF ENVIRONMENTAL RADIATION PROTECTION
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 _____

Address _____

City, State, Zip _____

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/PetCT
F. __ Bone Densitometer
G. __ Mammography
H. __ Stereotactic Breast Biopsy
I. __ Medical Accelerator/OBI
J __Therapy(0 KVP-1MV)Blachy Therapy
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 _____

3. Current Status of Equipment:

A. Has equipment been taken to new location? ☐ Yes ☐ No
If **no**, complete B, C, and D below:

If yes, address and phone of new location: _____

_____

Phone (____)_____-_____

B. Has equipment been sold? Yes ☐ No ☐ If yes, date of sale: ___ / ___ / _____
Month Day Year

Name of new owner: _____

Address:_____

_____

Phone: _____

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

Signature _____

Title _____ Date _____

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