



Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

December 1, 2021

Dear Facility Registrant:

If you have closed your office or no longer using the x-ray equipment that is registered with us, we need to know the status of the equipment.

Please complete the "Disposition of X-Ray Equipment" form and return the completed form to our office at the address shown below.

NYS DOH BERP
Radiation Equipment Section
ESP Corning Tower 12th Floor
Albany NY 12237

If you are disposing of all equipment for this registration location, return your original registration installation certificate with the disposition form by mail.

Until the equipment is removed or dismantled, and the attached disposition form is submitted to this office, the registrant is responsible for the registration fee.

Should you have further questions or need assistance, please phone (518) 402-7570 or email BERP@health.ny.gov

Enclosure: Disposition form

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 _____
City _____ State _____ Zip _____

3. Number and Type of Units

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

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 _____