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
   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: / / Year
      Month Day
   C. Has equipment been disassembled or scrapped? □ YES □ NO
      If yes, give date: / / Year
      Month Day
   D. Is equipment currently in use? □ YES □ NO
      Date stop using equipment: / / Year
      Month Day

New location of equipment (if applicable) __________________________

Phone (______) __________________

Signature of operator or RSO __________________________

Print Name __________________________

Title __________________________ Date __________________________

DOH-2126 (3/18)