

Oregon X-Ray Vendor/Consultant License Application

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| Department of Human Services 800 NE Oregon St. #640 voice: (971) 673-0490 | Radiation Protection Services Portland, OR 97232-2162 fax: (971) 673-0553 |
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|-------------------------------|--------|---------------------|-------------|
| This Box for Agency Use only: | | | |
| Approved | Denied | Reviewer's Initials | Review Date |

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| <ol style="list-style-type: none"> 1. Complete all items in this application for a new license or renewal of an existing license. Your application will not be accepted unless completed. 2. Use supplemental sheets where necessary. 3. Make one copy of the completed application for your records. 4. If you are completing the interactive .pdf application by computer, be sure to print the document before closing the file. On the PRINT menu, be sure DOCUMENT AND COMMENTS appears in PRINT WHAT box. Your entered text will disappear once the file is closed. <p>Upon review and approval of this application, you will receive an Oregon License issued in accordance with Oregon Administrative rules (OAR) Chapter 333 Division 101.</p> |
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| 1. This is an application for: (check the appropriate box) New License Renewal of License (License #) If Renewal, have there been any changes from your previous application? Yes No |
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| 2. Vendor Name | |
| PHYSICAL ADDRESS | MAILING ADDRESS |
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|----|-----------|--------------------|-------------------------------------|
| 3. | DAYS OPEN | HOURS OF OPERATION | Contact name for Compliance Issues: |
| | M | | Phone #: |
| | T | | fax: |
| | W | | e-mail address: |
| | Th | | |
| | F | | |
| | S | | |
| | Su | | |

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|------------------|---------------|
| 4. Owner's Name: | |
| MAILING ADDRESS | Phone: _____ |
| | fax: _____ |
| | e-mail: _____ |

5. Do you have more than one office or location? Yes No
 Address of secondary location:

* This license only covers employees who report to the address listed in box #2 of this application. Additional locations servicing Oregon require a location-specific license.

6. SUPERVISION OF SERVICE PROVIDERS

Please print or type name and title of individual who will be supervising those listed in box #7:
 Name: Title:

7. PROVIDERS OF SERVICE IN OREGON AND PROOF OF RADIATION SAFETY TRAINING

Please list below the names of all individuals who will be providing your service in Oregon. Attach documentation such as a copy of a syllabus and certificate indicating that each individual completed formal training (minimum 1 day) in Radiation Use and Safety. See OAR 333-101-0020(3) for requirements. Attach additional sheet if needed:

| NAME | TITLE |
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8. VENDOR CATEGORIES

* check categories for which you are applying and provide requisite documentation

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| 01. X-Ray Equipment Distributions 02. X-Ray Equipment Installer ¹ 03. X-Ray Equipment Repair Services ¹ 04. Health Physics Services ¹ 05. Medical Physicist/Qualified Expert ^{1,3} 06. X-Ray Machine Checks, Calibration, Etc. ¹ 07. Diagnostic X-Ray Shielding Consultant ^{1,4} | 08. Therapy Planning Consultant ^{1,3} 09. Personnel Dosimetry Services ⁵ 10. Radiation Survey Instrument 11. X-Ray Film Processor Services 12. Radiation Safety Training ⁶ 13. Other (Describe): |
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¹ OAR 333-101-0005(4) Radiation Survey Instruments required to assurance compliance with rules and regulations.
² Provide documentation indicating specific training in health physics including pertinent topic areas such as radiation physics, radiation biology, radiation safety/protection, etc.
³ OAR 333-100-0102 Documentation needed to indicate that you meet requirements for a *Qualified Expert*.
⁴ Provide documentation of training and experience in radiation shielding calculation, radiation safety/protection.
⁵ Provide documentation of current NVLAP accreditation.
⁶ OAR 333-106-0555(l) Courses and Instructors must be approved by the Agency. Send syllabus and hours demonstrating that the course meets the requirements of § 0055(l). Instructors must send documentation demonstrating that they meet the requirements of § 0055(2)(d).

9. TYPE OF FACILITY SERVICED

Medical
Therapy
Dental
Veterinary
Industrial

10. TRAINING AND EXPERIENCE QUALIFYING INDIVIDUAL TO PROVIDE SERVICE
 OAR 333-101-0020(3)(c)(A) List training and experience, pertinent to the vendor category for which you are applying, of those individuals who will be providing service in Oregon (*i.e.*, factory training in repair and service of specific X-ray machines, etc.). Please attach syllabus and certificates. Attach additional sheet(s) if necessary.

| NAME | COURSE | COURSE HOURS | YEAR TAKEN | YEARS OF EXPERIENCE |
|------|--------|--------------|------------|---------------------|
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11. PERSONNEL MONITORING * Required for all vendors who make X-ray exposures
 Monitoring Interval (check one): Monthly Quarterly
 Dosimetry Supplier:
 Address:

 Please note: Dosimetry provider must be NVLAP accredited. If unsure, visit the NVLAP website:
<http://ts.nist.gov/ts/htdocs/210/214/scopes/programs.htm>

12. RADIATION SURVEY INSTRUMENTS (attach additional sheet if needed)

| manufacturer | model # | last calibration date | calibration frequency |
|--------------|---------|-----------------------|-----------------------|
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Calibration performed _____
 Address: _____

13. UNDERSTANDING OF OREGON RULES

Each person providing service to registrants in Oregon must read and understand the requirements of the Oregon Rules for the Control of Radiation pertinent to his/her business. Oregon's rules may be viewed at:

<http://www.oregon.gov/dhs/ph/rps/index.shtml/shtml>

* Use the Quick Guide for list of those portions of the rules pertinent to your business (Medical, Dental, etc).

Please print the name of the certifying individual and sign where indicated.

I _____ attest that all individuals in box #7 of this form have read understood those portions of the Oregon Rules for the Control of Radiation pertinent to the type of service(s) our company will provide in Oregon. I further certify that the information provided in this application is true and correct to the best of my knowledge and belief.

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| SIGNATURE | TITLE | DATE |