Ontario

Ministry of Health and Long-Term Care

Form 1
X-ray Equipment Registration

Registration no.

Please use this number on all future correspondence

Please complete sections ABC and D

Collection of the information on this form, including the applicant's name, address and x-ray equipment information, is authorized under the *Healing Arts Radiation Protection Act*, R.S.O. 1990, c.H-2, Section 4. For further details concerning collection of this information please contact: The X-ray Inspection Service, Performance Improvement and Compliance Branch, 1075 Bay Street, 11th Floor, Toronto ON M5S 2B1, telephone: 416 327-7937, fax: 416 327-8805.

A. The x-ray machine(s) is(are) located at: *(Please give full address).*

Number, Street	Unit/Suite No.	Telephone No. ( )
City	Postal Code	Fax No. ( )
Name of X-ray Facility	Independent Health Facility Licence No.	
Name of Radiation Protection Officer (RPO)		Telephone No. ( )

B. Information about the owner of the x–ray machine.

*Name *(Please provide person's full name – do not use initials)*

If Business address is the same as address in section A, please check ☐. If different, complete the following:

Business address *(Please provide **full** address)*

Number, Street	Unit/Suite No.	Telephone No. ( )
City	Postal Code	Fax No. ( )
*Signature of owner - *same as person named above.*	Title	Telephone No. ( )

C. List *ALL* x–ray machines at the location indicated in section A above.

Type of facility ***(check one category only)*** ▶

D ☐ Dental H ☐ Hospital C ☐ X-ray Clinic

A ☐ Chiropractic T ☐ Podiotrist M ☐ Other Medical

Types of x-ray machine

DL = Dental CT = Computed (Axial) Tomography RM = Radiographic Mobile FL = Fluoroscopic

TH = Therapy MAM = Mammographic RA = Radiographi FM = Fluoroscopic Mobile

TL = Dermatology *(Enter 2 or 3 digit code in ** X–ray Type column below)* ▼ DP = Dual Purpose

Make/Model	**X-ray Type *(enter code from table above)*	Room No.	Date of Installation *(yyyy/mm/dd)*

Disponible en Français

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Make/Model	**X-ray Type *(enter code from table above)*	Room No.	Date of Installation *(yyyy/mm/dd)*

Please attach sheet of paper if more space is required

D. Additional x-ray machines

Does the owner also own, or own in partnership, X-ray machines at other locations ? ☐ No ☐ Yes *(please complete section below)*

Facility Name	Address in Full		Name(s) of Co-owner(s)
1.	Number, street name	Suite No.	
	City	Postal Code	
2.	Number, street name	Suite No.	
	City	Postal Code	
3.	Number, street name	Suite No.	
	City	Postal Code	
4.	Number, street name	Suite No.	
	City	Postal Code	
5.	Number, street name	Suite No.	
	City	Postal Code	
6.	Number, street name	Suite No.	
	City	Postal Code	
7.	Number, street name	Suite No.	
	City	Postal Code	

The owner undertakes to notify the Ministry within 15 days of changes of address or any other information given herein. Failure to do so is a violation of the HARP Act Section 4(3) and may be subject to a fine.

Return completed form to:

The Ministry of Health and Long-Term Care
X-Ray Inspection Service
Performance Improvement and Compliance Branch
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1