Ontario

Ministry of Health and Long-Term Care

Form 2 - Application for Approval of X-ray Installation

☐ Existing Owner

☐ New Applicant (No Registration Number)

Registration Number

Instructions

Return this form with electronic copy of the plan and one completed **Form 3** for each X-ray room requiring approval for radiation shielding to:

Ministry of Health and Long-Term Care
X-ray Inspection Service
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 416 327-7937 Facsimile: 416 327-8805
Submission of plan and relevant forms: xrisplans@ontario.ca
General Inquiries: xris@ontario.ca

For teaching institutions only

Will the X-ray machine(s) be used to irradiate humans?

☐ Yes. Proceed with this application.

☐ No. X-ray machine(s) will be used on non-humans only (e.g. animals, mannequins). Please contact this office for referral to Ministry of Labour.

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 3. For further details concerning collection of this information, please contact: X-ray Inspection Service, 5700 Yonge Street, 5th Floor, Toronto ON M2M 4K5, Telephone 416 327-7937, Fax 416 327-8805.

The undersigned, as owner or agent, applies for approval of a permanent X-ray location.

The application covers a total of _____ rooms. It is accompanied by the plan and one completed **Form 3** for each X-ray room for which approval is sought.

Note: Please refer to the Information Pamphlet for plan specifications and submission criteria. Omission of any details may result in the rejection of your application.

1. Owner or CEO/President of the X-ray Machine(s)

Last Name	First Name

Corporate Name

2. Radiation Protection Officer (RPO)

☐ Same as Owner of the X-ray machine(s) in **Section 1**

Last Name	First Name	Telephone Number

3. Location of X-ray Facility

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
	ON - Ontario	

Telephone Number ext.	Fax Number	Email Address

4. Type of X-ray Facility (select all that apply)

☐ Dental Facility

☐ Chiropractic Facility

☐ Podiatric Facility

☐ Hospital

☐ Independent Health Facility (IHF) IHF Billing Number _____

☐ Mammographic Facility

☐ Part of Ontario Breast Screening Program (OBSP)

☐ Other (Specify) _____

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5. Reason for Application (select all that apply)

☐ Opening new facility (specified in **Section 3**)

☐ Relocating existing facility to new facility specified in **Section 3**

Provide address of facility that is closing

Registration Number

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
	ON - Ontario	

☐ Complying with an inspector's direction

☐ Making equipment changes within existing facility specified in **Section 3**

- ☐ Adding new equipment
- ☐ Moving equipment
- ☐ Replacing equipment
- ☐ Making changes to the installation of existing equipment. Specify changes on **Form 3**.

6. Computerized Tomography (CT) Installation Only

This application is for installation of a:

☐ CT Scanner (non-dental)

- ☐ CT Letter of Designation attached

☐ Dental CT Scanner

- ☐ Letter of Request for CT Letter of Designation attached
- ☐ RCDSO issued CT Provisional Facility Permit attached

7. Return of Approved Plans

As of October 1, 2013, all approved plans are returned to the applicant via electronic mail.

Name and address of applicant:

☐ Same as **Section 1** (Owner) and **Section 3** (Location)

☐ Different from **Section 1** and **Section 3**

Last Name	First Name

Corporate Name

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
	ON - Ontario	

Telephone Number ext.	Fax Number	Email Address

8. Attestation

I attest that the information in this form is complete and accurate and that I am the owner or a delegate of the owner, authorized to submit this form.

Signature of Applicant	Date (yyyy/mm/dd)
X	