Ontario

Ministry of Health and Long-Term Care

Form 3 - X-ray Equipment and Shielding Specifications

The Healing Arts Radiation Protection Act. 1990.

Registration Number

Instructions

Submit one completed Form 3 for each X-ray room, along with Form 2 and the plan to xrisplans@ontario.ca. It is not mandatory to include your shielding assumptions (e.g., shielding calculations), relevant X-ray machine manual or user guide, scatter radiation data (SRD), and dose linear product numbers (3D/CBCT scanners) with your submission. However, doing so may result in less shielding being required.
Please ensure all appropriate areas are signed.

Equipment Identification

This form refers to X-ray room number _____ of _____ X-ray rooms for which approval is sought in this application.

The applicant identifies this room as _____ and it is so marked on the drawings.

This X-ray room will have _____ X-ray machine(s) installed.

The X-ray machine(s) installed in this room have _____ X-ray tube(s).

Make	Model	Year of Manufacture

Are the X-ray equipment parts (Image Receptor, X-ray Tube and X-ray Generator) supplied as one integrated unit by one manufacturer?

☐ Yes ☐ No (complete table)

	Make	Model
Image Receptor		
X-ray Tube		
X-ray Generator		

Type / Use of X-ray machine (select all that apply)

Dental

☐ Intra-oral ☐ Panoramic ☐ Dental Computerized Axial Tomography (e.g., CBCT, 3D)

☐ Cephalometric ☐ Other (specify) _____

Medical

☐ Radiographic ☐ Radiographic Mobile ☐ Fluoroscopic ☐ Fluoroscopic Mobile

☐ Mammographic ☐ Bone Mineral Density ☐ Radiation Therapy ☐ Computerized Axial Tomography

☐ Angiography ☐ Skull Unit ☐ Other (specify)

X-ray machine to be installed in this room

The maximum rated tube voltage is (kVp)	The maximum rated tube current is (mA)

Specify anticipated maximum workload for each modality that the X-ray machine can support.
Examples of modalities include intra-oral, panoramic, cephalometric, CBCT, 3D, radiographic, fluoroscopic, etc.

Mode	Type	Number of exposures per week	Maximum weekly workload (milliampere-minutes per week)	
			Primary tube	Auxiliary tube (if applicable)
	☐ Digital ☐ Film			
	☐ Digital ☐ Film			
	☐ Digital ☐ Film			

RPO Attestation
I attest, as the Radiation Protection Officer (RPO), that the **workload** values of the X-ray machine are accurate for my facility.

RPO Name	RPO Signature	Date (yyyy/mm/dd)

Important - The following information must be reconciled with your plan. The application cannot be processed without it.
State all measurements in metric units.

Room Construction

Item		Partitions		Material Composition (excluding framing)			Material Thickness(mm)		Lead	
		Height (m)	Length (m)	Material 1	Material 2	Cabinet	Material 1	Material 2	Height (m)	Thickness (mm)
Floor		m	m				mm	mm		mm
Walls	North	m	m				mm	mm	m	mm
	East	m	m				mm	mm	m	mm
	South	m	m				mm	mm	m	mm
	West	m	m				mm	mm	m	mm
Ceiling		m	m				mm	mm		mm
Door	1	m	m				mm	mm		mm
Door	2	m	m				mm	mm		mm
Control booth wall		m	m				mm	mm		mm
Control booth window		m	m				mm	mm		mm

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Adjacent Spaces

Space behind, (underneath, over)		Adjacent space occupied by	For what percentage of your working day is the space occupied? (%)	What percentage of the exposure time are the primary beam and auxiliary beam pointed toward this space?	
				Primary %	Auxiliary % (if applicable)
Floor					
Walls	North				
	East				
	South				
	West				
Ceiling					
Control booth					

Additional Shielding Information

Is there any additional shielding incorporated into the X-ray equipment or accessories (e.g. shielded and interlocked enclosures, leaded tables, chest-stands or other backdrops, etc.)

☐ No
☐ Yes (specify)

Submission of the following information regarding your image receptor is not mandatory but may result in less shielding being required if provided.

Type of shielding at image receptor	Thickness of shielding at image receptor	Leakage current at image receptor
	mm	mA

Will the primary beam be fully intercepted by the image receptor?

☐ No
☐ Yes

Additional Comments

Are you making any changes (alterations) to the installation of existing X-ray equipment specified on page 1?
(e.g., replacing image receptor, tube head, etc.)

☐ No
☐ Yes (specify change(s) made)

Please provide any additional information regarding the X-ray equipment and plan.

Note: Any subsequent changes and/or alterations made to the X-ray equipment, its use, location, or to the surrounding environment require re-approval. Please submit a new plan to this office **before** making any of the above changes.

On your plan, please include the limits of travel of the X-ray tube and image receptor within the room, the position and limits of rotation of the chair (dental only), and the room dimensions.

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

Applicant Name	Applicant Signature	Date (yyyy/mm/dd)

Ministry Use Only (Examiner's notes)