



EQUIPMENT REPLACEMENT NOTIFICATION

Facility Name: _____ Registration #: _____

Location Address: _____ Contact person: _____

Phone: _____

Mailing Address: _____ Fax: _____

E-mail: _____

Replacement Type: X-ray machine Control Generator Other (specify) _____

Equipment Location (Room #): _____

Current Shielding Log #: _____ Date unit out of service: _____

Equipment type (refer to list): _____

***Unit may not be released for patient use until Department approval is issued.**

Shielding Vendor Name: _____ Registration #: _____

Location Address: _____ Contact person: _____

Phone: _____

Mailing Address: _____ Fax: _____

E-mail: _____

Vendor Class (Check all that apply): Class III Class IV Class V Class VII Class VIII Class IX

By my signature, I certify that this is a like for like replacement with no other changes which would render the original shielding plan inaccurate, as required by RHB 4.4.2 in Regulation 61-64. Changes include but are not limited to equipment orientation, maximum technique factors, workloads as previously submitted, and occupancies of the surrounding areas as previously submitted.

Vendor Representative (print): _____ Vendor Representative (signature): _____

Sales Vendor Name: _____ Registration #: _____

Location Address: _____ Contact person: _____

Phone: _____

Mailing Address: _____ Fax: _____

E-mail: _____

**S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
BUREAU OF RADIOLOGICAL HEALTH
EQUIPMENT REPLACEMENT NOTIFICATION FORM**

PURPOSE: This form is for the notification of x-ray equipment replacement. Any facility planning to replace an x-ray producing machine, control or generator shall notify the Department prior to replacement.

ITEM BY ITEM INSTRUCTIONS:

Facility Name – Indicate the name of the person or company planning to replace an x-ray producing machine, control, or generator.

Registration # - Indicate the registration number under which the facility is registered with this Department.

Location Address – Indicate the address where the machine will be physically located, if different from the mailing address.

Contact person – The person responsible for the x-ray equipment to be replaced.

Phone – Self-explanatory.

Mailing Address – Indicate the Street, City, State, Zip Code.

Fax – Self-explanatory.

E-mail – Self-explanatory.

Replacement Type – Indicate what type of replacement will take place.

Equipment location – Room number or other indication where the unit will be located within the facility.

Current Shielding log # - Indicate the log # of the current shielding plan.

Date unit out of service – Self-explanatory.

Equipment Type – Indicate the equipment type using the list below.

Shielding Vendor name – Indicate the name of the vendor submitting the notification.

Registration # - Indicate the shielding vendor's registration #.

Location address – Indicate the Street, City, State, Zip Code.

Contact person – Indicate the name of the shielding vendor contact person.

Phone – Self-explanatory.

Mailing address – Indicate the Street, City, State, Zip Code.

Fax – Self-explanatory.

E-mail – Self-explanatory.

Vendor Class – Check the appropriate vendor class of the shielding vendor.

Vendor Representative – Printed name of person certifying notification.

Vendor Representative – Signature of person certifying notification.

Sales Vendor Name – Indicate the name of the vendor selling the replacement equipment and/or component.

Registration # - Indicate the sales vendor's registration #/

Location address – Indicate the Street, City, State, Zip Code.

Contact person – Indicate the name of the sales vendor contact person.

Phone – Self-explanatory.

Mailing address – Indicate the Street, City, State, Zip Code.

Fax – Self-explanatory.

E-mail – Self Explanatory.

DHEC use only – Document will be stamped with approval date and the new log #. A copy will be returned to the facility.

OFFICE MECHANICS AND FILING:

When the Equipment Replacement Notification forms are received, stamp the form with the date received. After review and approval, the form is stamped with the date of approval and the new log # and filed in the facility file. The retention schedule series for this form is 11908- X-Ray Files

Type of Equipment

Accelerator (Non-human use)

Baggage Checker

Bone Densitometer

Cabinet x-ray

C-arm fluoroscopic

Cephalometric

Ceph/Dental

Combination (Rad & Fluoro)

CT Scanner

CT Simulator

Dental

Dental CT

Diffraction

Electron Microscope

Fluoroscopic

Lithotripter

Mammography

Panoramic

Pan/ Dental

Pan/Ceph

Simulator

Spectrograph

Stereotactic

Therapy (Accelerator human use)

X-ray fluorescence (Non-medical)

X-ray gauge

Other (Specify)