RC FORM 200
(01/2024)

ARKANSAS DEPARTMENT OF HEALTH
RADIATION CONTROL SECTION

RADIATION MACHINE FACILITY REGISTRATION

Registration number - ______________
(to be assigned by ADH)

Part C to Section 1 of the ASBH Rules for Control of Sources of Ionizing Radiation states that each person (registrant) having physical possession or control of a radiation machine capable of producing radiation in the state of Arkansas shall apply for registration of such machine with the Department **within 30 days** of the date of acquisition. Fill out all applicable sections of RC FORM 200. Sign and date the form, then mail to: **Arkansas Department of Health, Radiation Control Section, X-ray Program, 4815 West Markham Street, Slot 30, Little Rock, Arkansas, 72205-3867**. Please print or type all entries. For questions, call the X-ray Program at (501) 661-2378.

NEW APPLICATION/ANNUAL FEE:

In accordance with RH-58, the following fee shall be paid for all x-ray units:

$65.00 per tube, up to a maximum of $260.00

Appropriate fee must in included with the registration application (check or money order). The application cannot be approved until payment is received. Thereafter, the annual fee may be paid online or by check or money order.

Invoices for annual fees are sent in November of each year. Failure to report an address change does not exempt a registrant from payment of fees and late penalties. A late fee equal to 10% of the applicable fee shall be charged for fees not received within 60 days of the invoiced due date and for every 60 days thereafter. Nonpayment of fees may also result in revocation of registration.

Please note that RH-27 requires that every registrant who permanently discontinues the use of, or permanently disposes of reportable sources of radiation shall notify the Department within **ten (10) days** of such action. THE ANNUAL FEE WILL CONTINUE TO BE ADDED TO YOUR REGISTRATION UNTIL THE DEPARTMENT IS NOTIFIED OF DISCONTINUANCE. **THE FEE WILL NOT BE WAIVED IF THE DEPARTMENT HAS NOT BEEN NOTIFIED.**

Facility Name:	**Telephone Number:** **E-mail:**
Facility Billing Address:	**Facility Physical Address:**
Applicant/Registrant Name: (if different from facility name)	**Radiation Safety Officer:** (Individual most responsible for x-ray operations)

Type of Registration:

- ☐ Chiropractic
- ☐ College/University
- ☐ Dental
- ☐ Hospital
- ☐ Industrial (includes facilities with analytical units)
- ☐ Mammography
- ☐ Physician (Private practices)
- ☐ Podiatry
- ☐ Veterinary
- ☐ Other (mobile services, etc.)
- ☐ Security Systems (Correctional Facilities, Police Depts., Court houses, Fire Departments, etc.)

**If the facility is a private practice that also offers another service (dental, chiropractic, etc.), select Physician

Machine Use Codes:
(Use when listing units on next page)

Code	Use
A	Analytical
BD	Bone Density
C	C-Arm
CH	Chiropractic
CR	Cabinet Radiography
CT	Computed Tomography (includes CBCT units)
CU	College/University (used for training purposes)
D	Dental
DCT	CBCT, 3D units
DP	Dental Panoramic
F	Fluoroscopic
H	Handheld
I	Industrial
M	Mobile
MA	Mammography
P	Podiatric
R	Radiographic
RF	Radiographic & Fluoroscopic Units (2 tubes)
S	Security Systems
T	Therapeutic Radiation Machines
V	Veterinary
O	Other units (those that are not in list above)

Room No. or Machine Location	Machine Use Code (see below)	Control Panel Manufacturer	Control Panel Model Name and No.	Control Panel Serial No.	No. of Tubes

Description of machines marked as "Other Units," if applicable:

Name of installer or transferee, as applicable:	Telephone Number:

CERTIFICATION

I hereby certify that:

A. I understand the applicable requirements of the ASBH Rules for Control of Sources of Ionizing Radiation, including, but not limited to, nonpayment of fees and safe operation of equipment.
B. All information contained in this registration is true and complete to the best of my knowledge.
C. I am the applicant or registrant or other individual duly authorized to act for and on his behalf.

Name:	Signature:
Title:	Date: