

REPORT OF ASSEMBLY OF CERTIFIED OR NON-CERTIFIED X-RAY SYSTEMS
FLORIDA DEPARTMENT OF HEALTH

Report of assembly of x-ray systems is applicable to installations or acquisitions from sale, lease, transfer, relocation, or disposal of radiation machines and/or major components. Completing this form to report the assembly or installation of an x-ray system or sub-system is required by State of Florida regulations. Anyone engaged in the business of assembling, replacing, or installing one or more components into an x-ray system is considered an assembler and is subject to this requirement. This report **MUST BE FILED WITHIN 15 DAYS** following the assembly/installation with the **Bureau of Radiation Control, Radiation Machine Section, 4052 Bald Cypress Way, Bin C21, Tallahassee, FL 32399-1741, phone (850) 245-4888, fax (850) 617-6442.**

1. EQUIPMENT LOCATION		DH Registration JR-		2. ASSEMBLER INFORMATION		DH Certificate V-	
a. Name of Hospital, Doctor, or Office where installed				a. Company Name			
b. Street Address				b. Street Address			
c. City			d. State	c. City			d. State
e. Zip Code		f. Telephone Number		e. Zip Code		f. Telephone Number	

3. GENERAL INFORMATION

a. Intended use(s) (check the applicable boxes)		
<input type="checkbox"/> GENERAL PURPOSE RADIOGRAPHY	<input type="checkbox"/> PODIATRY	<input type="checkbox"/> VETERINARY
<input type="checkbox"/> GENERAL PURPOSE FLUOROSCOPY	<input type="checkbox"/> UROLOGY	<input type="checkbox"/> HEAD - NECK (MEDICAL)
<input type="checkbox"/> TOMOGRAPHY	<input type="checkbox"/> MAMMOGRAPHY	<input type="checkbox"/> DENTAL - INTRAORAL
<input type="checkbox"/> ANGIOGRAPHY	<input type="checkbox"/> CHEST	<input type="checkbox"/> DENTAL - CEPHALOMETRIC
<input type="checkbox"/> RADIATION THERAPY SIMULATOR	<input type="checkbox"/> CHIROPRACTIC	<input type="checkbox"/> OTHER (*Specify in comments section)
b. The X-ray System is (check one)		c. The Master Control is in Room
<input type="checkbox"/> STATIONARY <input type="checkbox"/> MOBILE		d. Date of Assembly (MM/DD/YYYY)

4. COMPONENT INFORMATION

a. The Master Control is: <input type="checkbox"/> A NEW INSTALLATION <input type="checkbox"/> EXISTING (Certified) <input type="checkbox"/> EXISTING (Non-Certified)		
b. Control Manufacturer		c. Control Serial Number
d. Date Manufactured		
e. Control Model Number		f. System Model Name
g. Other Components (enter in the appropriate blocks how many of each you installed.)		
___ X-RAY CONTROL	___ IMAGE RECEPTOR SUPPORT DEVICE	___ FILM CHANGER
___ HIGH VOLTAGE GENERATOR	___ FLUOROSCOPIOIC AIR KERMA DISPLAY DEVICE	___ BEAM LIMITING DEVICE
___ VERTICAL CASSETTE HOLDER	___ IMAGE INTENSIFIER	___ FLUOROSCOPY IMAGING ASSEMBLY
___ TUBE HOUSING ASSEMBLY	___ SPOT FILM DEVICE	___ TUBE HOUSING ASSEMBLY (MEDICAL)
___ CEPHALOMETRIC DEVICE	___ DENTAL TUBE HEAD	___ IMAGE RECEPTOR
___ TABLE	___ CRADLE	___ OTHER _____

5. ASSEMBLER CERTIFICATION

I affirm I have assembled and/or installed, adjusted and tested all components identified above according to the instructions provided by the manufacturer(s) and in accordance with s. 404.22, F.S., and Florida Administrative Code Rule 64E-5.511.		
a. Printed Name	b. Signature	c. Date

***6. COMMENTS**