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, 705 Wells Road, Suite 300, Orange Park, Florida 32073, phone (904) 278-5730, fax (904) 278-5737.**

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

2. ASSEMBLER INFORMATION	DH Certificate V-
a. Company Name	
b. Street Address	
c. City	d. State
e. Zip Code	f. Telephone Number

3. GENERAL INFORMATION

a. Intended use(s) (*check the applicable boxes*)

☐ GENERAL PURPOSE RADIOGRAPHY	☐ PODIATRY	☐ VETERINARY
☐ GENERAL PURPOSE FLUOROSCOPY	☐ UROLOGY	☐ HEAD - NECK (MEDICAL)
☐ TOMOGRAPHY	☐ MAMMOGRAPHY	☐ DENTAL – INTRAORAL
☐ ANGIOGRAPHY	☐ CHEST	☐ DENTAL - CEPHALOMETRIC
☐ RADIATION THERAPY SIMULATOR	☐ CHIROPRACTIC	☐ OTHER (**Specify in comments section*)

b. The X-ray System is (*check one*)	c. The Master Control is in Room	d. Date of Assembly (MM/DD/YYYY)
☐ STATIONARY ☐ MOBILE		

4. COMPONENT INFORMATION

a. The Master Control is: ☐ A NEW INSTALLATION ☐ EXISTING (**Certified**) ☐ 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	____FLUOROSCOPOIC 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**____

____