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, Florida 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*)

☐ 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**_____

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