

Facility Certification Document
Form Approved OMB No. 0920-0020

NIOSH
Coal Workers' Health Surveillance Program
1095 Willowdale Rd.
Morgantown, WV 26505

Facility Name _____ Telephone Number _____

Street Address _____

City _____ State _____ Zip Code _____ County _____

Type of Facility (Mobile, Clinic, Private Office, Hospital, ...) _____ How many chest x-rays per year? _____

| X-Ray Units (Use N/A for does not apply) | Unit #1 | Unit #2 |
|--|---|---|
| Generator Manufacturer | _____ | _____ |
| Model | _____ | _____ |
| Date Acquired | _____ | _____ |
| Max. kVp / Max mA | _____ kVp / _____ mA | _____ kVp / _____ mA |
| Source to Film/Detector Distance | _____ <input type="checkbox"/> cm <input type="checkbox"/> in | _____ <input type="checkbox"/> cm <input type="checkbox"/> in |
| Phase | <input type="checkbox"/> Single <input type="checkbox"/> Three | <input type="checkbox"/> Single <input type="checkbox"/> Three |
| Pulse? (If Three Phase) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Battery Powered? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Capacitor Discharge? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type Anode | <input type="checkbox"/> Rotating <input type="checkbox"/> Stationary | <input type="checkbox"/> Rotating <input type="checkbox"/> Stationary |
| Grid Used? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grid Manufacturer | _____ | _____ |
| Type | <input type="checkbox"/> Stationary <input type="checkbox"/> Moving | <input type="checkbox"/> Stationary <input type="checkbox"/> Moving |
| Ratio / Lines per unit | _____ / _____ <input type="checkbox"/> cm <input type="checkbox"/> in | _____ / _____ <input type="checkbox"/> cm <input type="checkbox"/> in |
| Air Gap Used? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digital System Type | <input type="checkbox"/> CR <input type="checkbox"/> DR | <input type="checkbox"/> CR <input type="checkbox"/> DR |
| Manufacturer | _____ | _____ |
| Model | _____ | _____ |
| System Serial # | _____ | _____ |
| Software Version | _____ | _____ |
| Installation Date | _____ | _____ |
| Detector Size (cmXcm) | _____ | _____ |
| Image matrix (megapixels) | _____ | _____ |
| PACS Manufacturer | _____ | _____ |
| Last Radiation Inspection By / Date | _____ / _____ | _____ / _____ |
| Deficiencies and Date Corrected | _____ | _____ |

| Name(s) of X-ray Technologist(s) | Qualifications |
|----------------------------------|----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I agree to participate in this program in the manner specified by Part 37 of the Code of Federal Regulations (42 CFR Part 37), and understand that all information used in connection with this program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation.

| Name of physician in charge | Signature | Date |
|-----------------------------|-----------|-------|
| _____ | _____ | _____ |

Public reporting burden of this collection of this information is estimate to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA, 30333 ATTN:PRA (0920-0020). Do not send the completed form to this address.