Reset Form

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	_____ ☐ cm ☐ in	_____ ☐ cm ☐ in
Phase	☐ Single ☐ Three	☐ Single ☐ Three
Pulse? (If Three Phase)	☐ Yes ☐ No	☐ Yes ☐ No
Battery Powered?	☐ Yes ☐ No	☐ Yes ☐ No
Capacitor Discharge?	☐ Yes ☐ No	☐ Yes ☐ No
Type Anode	☐ Rotating ☐ Stationary	☐ Rotating ☐ Stationary
Grid Used?	☐ Yes ☐ No	☐ Yes ☐ No
Grid Manufacturer		
Type	☐ Stationary ☐ Moving	☐ Stationary ☐ Moving
Ratio / Lines per unit	_____ / _____ ☐ cm ☐ in	_____ / _____ ☐ cm ☐ in
Air Gap Used?	☐ Yes ☐ No	☐ Yes ☐ No
Digital System Type	☐ CR ☐ DR	☐ CR ☐ 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 participte 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 _____