

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.