

Attachment 6 –
Radiographic Facility Certification Document – Form 2.11

RADIOGRAPHIC FACILITY CERTIFICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

Form Approved
OMB No. 0920-0020
Exp.Date xx/xx/20xx
NIOSH
Coal Workers' Health Surveillance Program
1095 Willowdale Road, M/S LB208
Morgantown, WV 26505
Fax: 304-285-6058

Facility Name _____ Telephone Number _____
Street Address _____ Email _____
City _____ State _____ Zip Code _____ County _____
Type of Facility (Mobile, Clinic, Private Office, Hospital, ...) _____ How many chest x-rays per year? _____

Radiograph Units (Use N/A for does not apply)	Unit #1	Unit #2
NIOSH Facility Number - Unit Number	_____	_____
Room Number	_____	_____
Generator Manufacturer	_____	_____
Model	_____	_____
Date Acquired	_____	_____
Max kVp / Max mA	_____ kVp / _____ mA	_____ kVp / _____ mA
Source of 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?	<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
Ration / 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 Serials #	_____	_____
Software Version	_____	_____
Installation Date	_____	_____
Detector Size (cmXcm)	_____	_____
Image matrix (megapixels)	_____	_____
PACS Manufacturer	_____	_____
Last Radiation Inspection By / Date	_____ / _____	_____ / _____
Deficiencies and Date Corrected	_____	_____

Name(s) and Qualifications of Radiograph Technologist(s)

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 treated in a secure manner and will not be disclosed, unless otherwise compelled by law.

Name of physician in charge _____ Email Address _____ 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

