Reset Form

RADIOGRAPHIC FACILITY CERTIFICATION

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

NIOSH
Coal Workers' Health Surveillance
Program 1000 Frederick Lane, M/S LB208
Morgantown, WV 26508
Fax: 304-285-6058

Form Approved
OMB No.: 0920-0020

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	_____ ☐ cm ☐ in	_____ ☐ cm ☐ in
Phase	☐ Single ☐ Three	☐ Single ☐ Three
Pulse?	☐ 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 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

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