

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 _____ <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	
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 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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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/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS H21-8, Atlanta, GA, 30333 ATTN:PRA (0920-0020). Do not send the completed form to this address.