CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Office of Radiological Health
APPLICATION FOR CERTIFIED REGISTRATION
Therapeutic Radiation (LINAC) Units

INSTRUCTIONS: *See appropriate sections of NYC Health Code Article 175 for relevant information.*

Please type or print all information. Submit the completed application to:

Office of Radiological Health
New York City Department of Health and Mental Hygiene
42-09 28th Street, 14th Floor CN-56
Long Island City, New York 11101

Upon approval of an application, the applicant will receive a "Certified Registration" issued pursuant to statutory and implementing regulatory authority and subject to all applicable rules, regulations and orders of all appropriate regulatory agencies now or hereafter in effect and to any conditions specified in the certified registration document.

1. Name & mailing address of applicant (include zip code):

2. Radiation Safety Officer:

Telephone No. ( ) _____

Facsimile No. ( ) _____

email: _____

3. Individual to be contacted about this application:

Telephone No. ( ) _____

Facsimile No. ( ) _____

email: _____

4. This is an application for (check one)

[ ] New Certified Registration

[ ] Amendment to Registration number : _____

[ ] Renewal of Registration number: _____

5. Certification (this item must be completed by applicant):

THE APPLICANT AND ANY OFFICIAL EXECUTING THIS CERTIFICATION ON BEHALF OF THE APPLICANT NAMED IN ITEM 1 CERTIFY THAT ALL INFORMATION CONTAINED HEREIN, INCLUDING ANY SUPPLEMENTS ATTACHED HERETO, IS TRUE AND CORRECT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Date: _____ _____
(Signature of Applicant named in Item 1)

By: _____ _____
(Signature-Certifying Official) (Typed or Printed Name of Certifying Official)

_____
(Title of Certifying Official)

Note: Any misrepresentation of any material fact found to have been made in securing a registration pursuant to this application shall constitute cause for the suspension or revocation of such registration and may subject the applicant to such other penalties that may be provided for in the New York State Public Health Law or the New York City Health Code.

Continued overleaf . . .

APPLICATION FOR CERTIFIED REGISTARTION
Therapeutic Radiation (LINAC) Units

Supplemental Form A – Facility Information

6. Location where unit will be used or possessed (use extra sheets for LINACs in multiple locations) :

_____
Building Name

_____
Street Address

_____
Floor and Suite/Room#

_____
City, State Zip code

7. Authorized Therapy Physicists (add extra sheets if necessary):

Name: _____
(For chief physicist include phone and email address)
_____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Continued overleaf . . .

APPLICATION FOR CERTIFIED REGISTARTION
Therapeutic Radiation (LINAC) Units

Supplemental Form A – Facility Information

8. Authorized Users (add extra sheets if necessary):

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

9. Purpose for which therapeutic machines will be used:

Continued overleaf . . .

APPLICATION FOR CERTIFIED REGISTARTION
Therapeutic Radiation (LINAC) Units

Supplemental Form B – Unit Information

Complete the following for each Therapeutic Radiation Unit

10. LINAC Technical Information (attach additional sheet if necessary):

Manufacturer's name: _____

Model/Serial No: _____

Operating Mode: ☐ IMRT ☐ SBRT ☐ SRT ☐ IGRT ☐ TOMO ☐ Other (specify _____)

Does the unit employ a beam stop?

☐ Yes ☐ No

If Yes, is it

☐ Fixed ☐ Removable

Electron beam energies:	Photon beam energies:	Maximum "beam on" output radiation++
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++ List the maximum output radiation for each modality

10. LINAC Technical Information (attach additional sheet if necessary):

Manufacturer's name: _____

Model/Serial No: _____

Operating Mode: ☐ IMRT ☐ SBRT ☐ SRT ☐ IGRT ☐ TOMO ☐ Other (specify _____)

Does the unit employ a beam stop?

☐ Yes ☐ No

If Yes, is it

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Electron beam energies:	Photon beam energies:	Maximum "beam on" output radiation++
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++ List the maximum output radiation for each modality

Continued overleaf . . .

APPLICATION FOR CERTIFIED REGISTARTION
Therapeutic Radiation (LINAC) Units

Supplemental Form B – Unit Information

Complete the following for each Therapeutic Radiation Unit (copy this form if necessary).

10. LINAC Technical Information (attach additional sheet if necessary):

Manufacturer's name: _____

Model/Serial No: _____

Operating Mode: ☐ IMRT ☐ SBRT ☐ SRT ☐ IGRT ☐ TOMO ☐ Other (specify _____)

Does the unit employ a beam stop?

☐ Yes ☐ No

If Yes, is it

☐ Fixed ☐ Removable

Electron beam energies:	Photon beam energies:	Maximum "beam on" output radiation++
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++ List the maximum output radiation for each modality

11. Equipment used to conduct radiation survey. Please list.

Instrument	Manufacturer	Model	Range

12. Dosimetry system equipment used to measure beam output. Please list.

Instrument	Manufacturer	Model	Range

Applicant must sign the following stipulation:

The registrant agrees to conduct full calibration output measurements according to Task Group #51 Protocol (or a more recent version) for Determination of Absorbed Dose from High Energy Photon and Electron Beams and agrees to adapt all measurements as listed in Table II: Quality Assurance of Medical Accelerators in Task Group #142 (or a more recent version): Comprehensive Quality Assurance for Radiation Oncology.

_____

Signature

 Continued overleaf

APPLICATION FOR CERTIFIED REGISTARTION
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Supplemental Form C – Radiation Safety

13. Training and experience of Radiation Safety Officer, Authorized Users, and Authorized Therapy Physicists.

14. Training for individuals working in or frequenting restricted areas.

15. Facilities and Equipment (including floor diagrams indicating key locations at each LINAC facility; shielding studies; any equipment not listed under items number 11 and 12 above).

16. Radiation safety and quality assurance program (including but not limited to ALARA program, personal dosimetry, area survey, emergency procedure, pregnant workers' program, patient identification, periodic Q/A program and checklist of actions).

- Please provide acceptance testing/commissioning report (including detailed radiation surveys) for newly installed LINACs or for those that have undergone considerable modifications

YOUR APPLICATION WILL NOT BE PROCESSED AND WILL BE RETURNED IF THE REQUIREMENTS BELOW ARE NOT INCLUDED

ALL APPLICANTS MUST SUBMIT WORKERS' COMPENSATION AND DISABILITY INSURANCE PROOF WITH COMPLETED APPLICATION.

If you don't submit workers' compensation and disability insurance – you must complete and submit a Certificate of Attestation of Exemption Form CE-200. You can obtain this form at HTTP://WWW.WCB.STATE.NY.US/CONTENT.MAIN/FORMS/CE200APPLY.PDF