Instructions for Applying for a Health Department Radiation Producing Equipment (X-Ray) Permit

The owner or operator of any radiation installation or of any radiation equipment in operable condition intended to be used for patient clinical diagnosis and/or treatment must obtain a current Radiation Producing Equipment - Certificate of Registration from the NYC Department of Health and Mental Hygiene (DOHMH) in order to establish (set up), maintain or operate such equipment. Registrations are categorized by facility, and where applicable, permit and establishment type numbers.

Annual Fee: $100

You may apply online or in person.

Apply On-Line

1. Go to www.nyc.gov/healthpermits, select the permit for which you are applying and review the prerequisites and required supporting documents.
2. Gather all supporting documentation that must be submitted along with the application (see *Supporting Documents* and *Checklist of Required Documentation*).
3. Create electronic versions of your supporting documents
4. Select Apply Online and you will register an account with the NYC Online Licensing system.
5. Complete the required information online, upload your supporting documents and submit payment.
6. Payment accepted: Credit/Debit Cards only.

Apply In Person

1. Obtain an application packet by:
    a. Calling 311 and asking for *Apply for a Radiation Producing Equipment Permit*
    b. Download application forms and instructions from www.nyc.gov/healthpermits.
2. Gather all supporting documentation that must be submitted along with the application (see *Supporting Documents* and *Checklist of Required Documentation*).
3. Complete the Application for a Permit form and the Supplemental Forms.
4. Submit the Application form, Supplemental Forms, and all supporting documents, along with payment, to:
    DCA Licensing Center
    42 Broadway
    Manhattan
    Hours: M, Tu, Th, Fr: 9 am – 5 pm; We: 8:30 – 5 pm
5. Payment Accepted: Money Order, Credit/Debit Cards, Checks (no cash accepted)

Instructions for Applying for a Health Department Radiation Producing Equipment (X-Ray) Permit

A. Important Information – *Read the Following Before You Apply for a Permit*

1. X-ray permits are only issued in the name of a medical practitioner licensed in New York State(i.e. physician, chiropractor, doctor of osteopathy, dentist, podiatrist, or veterinarian);
2. You will be required to provide proof of Certificate of Disability Insurance and Workers Compensation Insurance for your facility or form CE-200 if you are exempt. For information on this requirement, go to http://www.wcb.ny.gov.
3. You will be required to submit technical documents in regard to each x-ray unit that you will to register as detailed in the checklist below;
4. If you have not submitted all the required documents and information requested , your application process will not proceed forward until all documents and/or information are supplied to the satisfaction of the Dept. of Health.

B. Supporting Documents

For Dental and Podiatrist Offices ONLY

- Dental and podiatric facilities must contact a DOHMH-certified CRESO (Certified Radiation Equipment Safety Officer) to secure an inspection (see attached list).
- Copy of full CRESO report including cover sheet and RAD 8 form for each unit.

For Veterinarian offices ONLY

- Veterinary facilities must contact a DOHMH-certified CRESO (Certified Radiation Equipment Safety Officer) to perform ONLY a Radiation Protection Survey AND must contact the DOHMH Office of Radiological Health to schedule a pre-permit inspection. (718) 310-2840.
- Copy of radiation protection survey conducted by CRESO.

For all other medical establishments

Type of Unit	Quality Control Report[1]	Radiation Protection Report	ESE Measurements[2]
Radiographic	√	√	√
Fluoroscopic	√		√
CT Scanner	√	√	√
CBCT Scanner	√	√	√
Bone Densitometer		√	

[1] Acceptance testing of unit including all Quality control tests mandated by the Health Code for this type of unit

[2] ESE (Entrance Skin Exposure) measured values for the most common x-ray Exams at your facility. For fluoroscopic units, it means the ESEs value for the most common fluoroscopic exam by patient size.

Instructions for Applying for a Health Department Radiation Producing Equipment (X-Ray) Permit

<u>For Non-Medical Offices</u> (i.e., Commercial Building, Industrial Facilities, research facilities).

Type of Unit	Quality Control Report[1]	Radiation Protection Report	ESE Measurements[2]
Radiographic		√	
Fluoroscopic		√	
CT Scanner		√	

See also ***Checklist of Required Documentation for All New Permit Applications,*** attached**.**

For assistance in applying for a permit, call (718) 310-2840.

NYC Health

Certified Radiation Equipment Safety Officers (CRESO)

CRESO	Address	Phone Number	E-Mail Address
Ronald Restivo	167-11 33rd Avenue Flushing, NY 11358	(718) 463-4664	N/A
Alfonso Buffa	40-10 73rd Avenue Woodside, NY 11377	(917) 518-8667	abuffa@earthlink.net
Hung Ching	54-15 32nd Street Queens, NY 11377	(917) 331-3144	checkradiation@gmail.com
James So	321 Bennets Lane Somerset, NJ 08873	(973) 239-8477	js998@columbia.edu
Bun Chan	728 Shady Path Lane Franklin Lakes, NJ 07417	(201) 321-8685	CCNUCL@optonline.net
Joseph Donnelly	140 East 40th Street, Apt 10H New York, NY 10016	(212) 338-0910	ritome@gmail.com
Philip M. Lorio	244-39 86th Road Bellerose, NY 11426	(718) 347-2761	N/A
Jose Antony	421 Benito Street East Meadow, NY 11554	(516) 538-2601	Jantony@NSHS.edu
Steven Wagner	74-02 Kessel Street Forest Hills, NY 11375	(212) 263-6888	steven.wagner@nyumc.org
Viji Mathew	PO Box 680 New York, NY 10009	(646) 228-1158	vmathew01@gmail.com
Martin Schnee	3733 Laurel Avenue Brooklyn, NY 11224	(718) 373-6348	scientist004@aol.com
Maxine Barnes	100 Casals Place, Apt 15D Bronx, NY 10475	(718) 320-5374	maxine.barnes@att.net
George Sommer	107-40 Queens Boulevard Apt. 9G Forest Hills, NY 11375	(917) 647-5811	george.somm@yahoo.com
Louis Mazzola	P.O. Box 5 Bronx, NY 10465	(718) 427-7970	pmdirac@optonline.net
James Sheffield	100 Elgar Street, Apt. 25H Bronx, NY 10475	N/A	N/A
Serafini Prado	P.O. Box 604679 Bayside, NY 11360-4679	(718) 225-4031	sprado@msn.com
Yusuf Erdi	Memorial Sloan Kettering Cancer Center Dept Medical Physics 1275 York Avenue, S-119 New York, NY 10065-6007	(212) 639-7365	erdiy@mskcc.org
Eugene Lief	3 Manger Circle Pelham, NY 10803	(347) 668-2420	eugenelief@hotmail.com
Alex Voxakis	2185 Lemoine Avenue, Apt 6H Fort Lee, NJ 07024	(201) 562-2013	N/A
A. Elfaham	139 97th Street Brooklyn, NY 11209	(917) 607-1955	Elfaham2686@aol.com
Sree Murthy	Physics Consulting 22 Poillon Avenue Staten Island, NY 10312	(917) 612-0954	SreePci@aol.com

Instructions for Applying for a Health Department Radiation Producing Equipment (X-Ray) Permit

Checklist of Required Documentation for All New Permit Applications (check individual permit guidelines for additional permit-specific required documentation)

Items Needed *Be sure the applicant's name is the same on all documents. See "Instructions for Completing an Application" for more details.*	**Legal Business Structure**		
	Individual	Partnership	Corporation or LLC
Permit Application • All applicable sections completed • Supplemental Form(s) if applicable • Signed by applicant (example: owner, officer, director or shareholder)	✓	✓	✓
Permit Fee • See list of permit fees • Credit card, money order or check payable to "DOHMH" • Not-for-profits: no fee if proof of status is submitted (see below)	✓	✓	✓
Proof of Home Address (one of the following) • Valid driver's license or non-driver ID • Current lease or mortgage statement • Utility bill, bank or credit card statement dated within the last 90 days • "Affidavit of Home Address" form, completed by a person living with applicant and a recent utility bill or lease in that individual's name	✓	✓ (needed for partnership of individuals only)	
Photo Identification One government-issued ID with photo, such as: • Driver's license or non-driver ID • Alien Registration Card or Naturalization Certificate • U.S. or foreign passport	✓	✓	✓
Proof of Sales Tax Collecting Authority • Valid original NYS Certificate of Sales Tax Authority *Obtain at http://www.nys-opal.com. Complete Form DTF-17 on-line or mail it to New York State Tax Department, Sales Tax Registration Unit, W A Harriman Campus, Albany, New York 12227. Takes 4-6 weeks.*	✓	✓	✓
Proof of Incorporation • Certificate of Incorporation (stamped to show it was filed with the New York State Department of State) or Filing Receipt issued by the NYS Secretary of State. *If located outside of New York State, obtain "Certificate of Good Standing" from your Secretary of State and file with application for "Authority to Conduct Business in New York State" with NYS Department of State. You must then present this "Authority" issued by the NYS Department of State when you apply for this permit.*		✓ (needed for partnership of corporations or LLCs only)	✓
Workers' Compensation & Disability Insurance Coverage • Submit proof of coverage effective when the establishment begins operation, including insurer's name, policy number, and expiration date. If such coverage is *NOT* required, submit Certificate of Attestation of Exemption (Form CE-200) from the NYS Workers' Compensation Board showing the applicant's Exemption Number and the date issued. See http://www.wcb.ny.gov. • List DOHMH as the certificate holder (**not** the policy holder)	✓	✓	✓
Payment of Outstanding Fines for DOHMH Violations (if any) • Certified check, credit card or money order payable to "OATH Health Tribunal" (in person payment) or pay online with credit or debit card	✓	✓	✓
Proof of Not-for-Profit Status (if applicable)* • Letter from the IRS stating not-for-profit status*		✓	✓
Power of Attorney or Authority to Act Affidavit (if applicable) • If someone else will turn in the application for you	✓	✓	✓

Instructions for Applying for a Health Department Radiation Producing Equipment (X-Ray) Permit

Instructions for Completing a Standard Application Form

New York City Health Code, Section 3.19 states: "No person shall make a false, untrue or misleading statement or forge the signature of another on a certificate, application, registration, report, or other document required to be prepared pursuant to this Code. No person shall make a false, untrue or misleading oral statement to the Department as to any matter investigated by the Department."

NOTE: Any form with alterations, corrections, whiteout, etc., will not be accepted.

Complete all sections of the application. If completing it by hand, please use ink and print in **CAPITAL LETTERS**.

1. **License or Permit Name**
   - Enter the name of the permit or license you want to obtain. Example: Radiological Equipment Permit
2. **Section A**
   - Enter the individual owner's name, or all partners' names or corporation name in the box labeled "Name of Corporation, partnership or individual owner" (the permit will be issued to the corporation, partnership or person named here)
   - Enter the name of the establishment in the space labeled "Trade Name/DBA"
   - Provide the address where the establishment will be located. Please include in the space labeled "Premises Location" the floor, booth number, or store number where the establishment is to be located.
   - Enter the establishment's telephone, fax and the email address (if any). All correspondence sent by email will be sent to this address.
   - Provide your date of birth, if applying as an individual
3. **Section B**
   - Enter the date you expect to start operating.
4. **Section C**
   - Enter your New York State Tax Authority ID #. Not-for-Profit applicants should enter their Federal EIN. If applying as an individual, <u>also</u> enter your SSN. If you do not have a Social Security number, you may use an Individual Tax Identification Number (ITIN)
5. **Section D**
   - Enter the mailing address if it is different from where the establishment is going to be located. All correspondence sent by mail will be sent to this address.
6. **Section E**
   - Enter the name, home address, zip code, phone number, email address and title of the owner/all partners in the business/all principal officers in the corporation
7. **Section F**
   - All applicants must complete the Workers' Compensation and Disability Insurance information requested and provide copies of proof of current insurance or form CE-200 stamped by the Worker's Compensation Board, indicating the Board received a sworn affidavit stating that such coverage is not required. An application for a permit will not be accepted without this information and proof
8. **Signature**
   - Sign the application.
     - *Note: the person who signs the Application must be named in Section E.*
   - Enter the title and telephone number of the person who signed the Application for Permit
   - Indicate whether the applicant is 18 years of age or older.
     - *Note: applicants must be older than 18 years of age.*

STANDARD APPLICATION FOR NEW LICENSE OR PERMIT

NYC Health

APPLICATION DATE		
MONTH	DAY	YEAR

FOR OFFICE USE					
CAMIS/RECORD NUMBER		LICENSE/PERMIT			
		TYPE	FEE CLASS/ SUBCLASS		
		H			
EXPIRATION DATE			FEE AMOUNT ➤	DOLLARS	CENTS
MO	DAY	YEAR			

NAME OF LICENSE/PERMIT
(For detailed instructions and information about what is required to apply for this permit, please go to www.nyc.gov/healthpermits)

IMPORTANT: Please type or print legibly in ink using capital letters. Allow spaces between completed words or numbers. Standard abbreviations are permitted. All sections must be completed in ink.

SECTION A – NAME, ADDRESS AND CONTACT INFORMATION OF ENTITY TO WHICH LICENSE/PERMIT IS TO BE ISSUED

READ CAREFULLY: *Enter the corporate name and location of business establishment. If not incorporated, enter your name(s) and location of business establishment.*

NAME OF CORPORATION, PARTNERSHIP, PARTNERS OR INDIVIDUAL OWNER *(Last Name First)*			TELEPHONE NUMBER (AREA CODE)
TRADE NAME/Doing Business As (DBA)			FAX NUMBER (AREA CODE)
BUILDING NUMBER	STREET		PREMISES LOCATION (FLOOR, STORE #, BOOTH #)
CITY OR TOWN	STATE	ZIP CODE	E-MAIL ADDRESS (REQUIRED)

DATE OF BIRTH (If applying as an individual)	MONTH	DAY	YEAR	OPTIONAL
				GENDER: ☐ Male ☐ Female

Language Preference for Inspections: If the permit you are applying for requires an inspection by the Department of Health and Mental Hygiene, do you prefer that this inspection be conducted in, or translated to, a language other than English? ___ No ___ Yes
If "yes" that language is _____.

☐ I agree to receive all official notices from the Department of Health only by **email** at the **email** address provided in this application form. An official notice is any correspondence from the Department of Health that requires a response by a date certain. These include, but are not limited to, permit or license renewal notices; notices of fines or fees owed; collection letters and Dunning Notices, and Notices of Violations.

☐ I would like to receive Department of Health publications, including information about new regulations, newsletters, fact sheets and other educational material, only by **email** at the **email** address provided in this application form.

SECTION B – DATE EXPECTED TO OPEN/START OPERATING		
MONTH	DAY	YEAR

SECTION C – NYS SALES TAX ID#	SOCIAL SECURITY NUMBER (If applying as an individual)	ITIN NUMBER (If no SSN and applying as an individual)
___—___		

SECTION D – MAILING ADDRESS, IF DIFFERENT FROM PERMITTED/LICENSED ESTABLISHMENT'S ADDRESS (INCLUDE APARTMENT #, PO BOX #)

STREET ADDRESS		
CITY OR TOWN	STATE	ZIP CODE

CITYWIDE LICENSING CENTER – DEPARTMENT OF HEALTH AND MENTAL HYGIENE – 42 BROADWAY, NEW YORK, NY 10004

(continued on next page)

SECTION E – LIST NAMES (LAST, FIRST) OF OWNER – PARTNER – CORPORATE OFFICERS

1	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET	CITY		STATE	ZIP CODE
2	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET	CITY		STATE	ZIP CODE
3	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET	CITY		STATE	ZIP CODE
4	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET	CITY		STATE	ZIP CODE

SECTION F

ALL APPLICANTS (EXCEPT THOSE APPLICANTS FOR A MOBILE FOOD VENDING LICENSE, TATTOO LICENCE OR A HORSE LICENSE) MUST COMPLETE THIS SECTION REQUESTING WORKERS' COMPENSATION AND DISABILITY BENEFITS INSURANCE INFORMATION AND PROVIDE COPIES OF PROOF OF CURRENT INSURANCE IF IT IS REQUIRED.

YOUR APPLICATION FOR A PERMIT WILL NOT BE ACCEPTED IF YOU DO NOT COMPLETE THIS SECTION AND PROVIDE THIS INFORMATION AND PROOF IF YOU ARE REQUIRED TO HAVE THIS INSURANCE.

Please check the appropriate box:

☐ The business described in this application has Workers' Compensation and Disability Benefits Insurance as identified below:

Workers' Compensation Insurance Carrier: _____ Policy #: _____ Expiration Date: _____

Disability Benefits Insurance Carrier: _____ Policy #: _____ Expiration Date: _____

OR

☐ Form CE-200 was submitted to the Worker's Compensation Board stating such coverage is not required for this business and a copy with the New York State-assigned Exemption Certificate Number is attached.

Certificate Number: _____ Issuance Date: _____

Form CE-200 attesting to an exemption of this requirement can be found at http://www.wcb.ny.gov

Legal reasons for an applicant to qualify for this exemption are listed on Form CE-200. Please review Form CE-200 to see if your business qualifies for this exemption and is not required to obtain Workers' Compensation and Disability Benefits Insurance.

By signing this application for a permit, I agree that I will comply with provisions of the Health Code and other laws that apply to the permitted activity, and that all the statements made in this application are true and complete. Making a false statement is an offense punishable by fines, imprisonment or both. (NYC Administrative Code § 10-154.)	TITLE	ARE YOU 18 YEARS OF AGE OR OVER? ☐ YES ☐ NO
SIGNATURE OF BUSINESS OWNER, PARTNER, OR CORPORATE OFFICER	TELEPHONE NUMBER	

ARE YOU REGISTERED TO VOTE?

If not, you may request a Voter Registration form when you submit your application, or you can access www.nyccfb.info/nyc-votes online.

CITYWIDE LICENSING CENTER – DEPARTMENT OF HEALTH AND MENTAL HYGIENE – 42 BROADWAY, NEW YORK, NY 10004

APPLICATION FOR A LICENSE OR PERMIT

Radiation Producing Equipment

Supplemental Information

FACILITY INFORMATION

OPERATING HOURS

DAYS OF WEEK	OPENING TIME	CLOSING TIME
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

FACILITY TYPE

- ☐ Hospital
- ☐ Non-Hospital
- ☐ Veterinarian
- ☐ Podiatric
- ☐ Dental

FACILITY INFORMATION

Do you expect to conduct more than 2,500 patient exams per year?

☐ Yes ☐ No

Are you a facility that will have Veterinarian equipment?

☐ Yes ☐ No

Are you a facility that will have Dental equipment?

☐ Yes ☐ No

Are you a facility that will have Podiatric equipment?

☐ Yes ☐ No

Will Radiation Producing Equipment be used in a mobile van?

☐ Yes ☐ No

If yes, provide VIN for van:

_____

X-RAY PATIENTS PER YEAR

Expected number of **Patients** undergoing X-Rays per year: _____

INTERPRETING PHYSICIAN(s)

Will you have Onsite or Offsite Interpreting Physician(s)?

☐ Onsite ☐ Off-site

PROGRAM USE ONLY

Inspection Priority:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

APPLICATION FOR A LICENSE OR PERMIT

Radiation Producting Equipment

NYC Health

UNIT INFORMATION

(Complete this form for each unit)

LOCATION TYPE

- ☐ OR (Operating Room)
- ☐ CT Suite
- ☐ Cardiac Cath Lab
- ☐ Electrophysiology Lab
- ☐ Main Radiology
- ☐ Cysto Lab
- ☐ Mammography Suite
- ☐ Special Procedures Suite
- ☐ Hospital Dental Suite
- ☐ Vascular Operating Room
- ☐ X-ray Room
- ☐ Podiatric X-ray Room
- ☐ Dental X-ray Room
- ☐ Fluoroscopy Suite
- ☐ Radiographic X-ray Room
- ☐ Other

BUILDING NAME:

_____

(required only if Facility Type = Hospital needs)

Floor: _____

Location Name: _____

Room #: _____

EQUIPMENT TYPE

- ☐ Dental
- ☐ Fluoroscopic
- ☐ Mammographic
- ☐ Radiographic
- ☐ Therapy
- ☐ Academic/Commercial

Fixed or Not?

☐ Fixed ☐ Mobile

Machine Number:

_____

(required only if Mobile Unit

Number of Tubes:

Rated kV:

Year Manufactured:

Model #:

Installed Date:

SUBTYPE

- ☐ Analog
- ☐ Bone Densitometer
- ☐ C-Arm Fixed
- ☐ C-Arm Mobile
- ☐ CT
- ☐ Cephalometric
- ☐ Cone Beam CT
- ☐ Dental
- ☐ Digital
- ☐ Fixed
- ☐ Grenz Rays
- ☐ Linear Accelarator
- ☐ Mini C-Arm
- ☐ Mobile
- ☐ Ortho Voltage
- ☐ Panoramic
- ☐ Podiatric
- ☐ R/F
- ☐ Electron microscope
- ☐ X-ray diffraction equipment
- ☐ X-ray baggage screening units
- ☐ X-ray cabinet security system
- ☐ Stereotactic

MANUFACTURER

- ☐ Acoma Medical
- ☐ Eureka
- ☐ General Electric
- ☐ GE/OEC
- ☐ Genoray America
- ☐ Hologic, Inc.
- ☐ Machlett
- ☐ Midmark Corp
- ☐ MinX-ray, Inc
- ☐ OEC Medical
- ☐ Picker Intl
- ☐ Phillips
- ☐ Shimadzu
- ☐ Siemens/Acusion
- ☐ Sonosite
- ☐ Sounmed 2D
- ☐ Summit Indust
- ☐ Trex Medical Corp
- ☐ Xonics
- ☐ Ziehm
- ☐ Other (write in Name of Mfgr)

_____