



## Instructions for Applying for a Health Department Linear Accelerator (LINAC) Permit

The owner or operator of a therapeutic medical linear accelerator (LINAC) or radiation therapy unit capable of operating at 500 kV (photons) and/or 500 keV (electrons) **OR HIGHER** must apply for a Certified Registration from the New York City Department of Health and Mental Hygiene (DOHMH). Certified Registrations are issued to hospitals, private physicians, veterinary clinics or veterinarians which provide radiation therapy.

### Fees:

New Facility	\$600.00	5 (five) Year certified registration
Renewal Facility	\$600.00	5 (five) Year certified registration
All Amendments	\$235.00	

*You may apply online or in person.*

### Apply On-Line

1. Go to [www.nyc.gov/healthpermits](http://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 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 Linear Accelerator permit*.
  - b. Download application forms and instructions from [www.nyc.gov/healthpermits](http://www.nyc.gov/healthpermits).
2. Gather all supporting documentation that must be submitted along with the application (see *Supporting Document Checklist* below).
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, 5<sup>th</sup> floor  
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)



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### ***A. Supporting Documents (Read the Following Before You Apply)***

1. Note that the individual signing this application certifies the authenticity of the information supplied in this application. In a medical center/hospital location, the certifying official shall be hospital management
2. Applicant shall submit documentation that describes the training and experience of authorized users listed in Attachment 1, individuals responsible for radiation safety program, and therapy physicist.
3. Applicant shall submit a document that describes the Instruction for individuals working in or frequenting restricted areas.
4. Facilities and equipment Requirements – Each applicant shall submit the following documentation:
  - A radiation protection survey.
  - The direction in which the therapy x-ray unit head can be moved and describe the maximum angle from the vertical of the beam orientation in each direction.
  - A drawing of the linac, the linac vault, and the shielding, including dimensions
  - A list of the equipment at the facilities utilized to conduct radiation surveys, and the dosimetry system utilized to measure beam output. For each instrument at the facility, describe the manufacturer, model, and ranges the instrument is capable of measuring.
  - A copy of the calibration for this unit in accordance with Code requirements for the dosimetry system utilized to calibrate the beam output, please supply.
5. Radiation safety program - Each applicant must submit the following with their application:
  - Personnel Monitoring - proposed facility policy and name of film badge vendor for the facility.
  - Operating Policies for the Facility - a copy of the facility's policies.
  - Emergency Procedures - a copy of the facility's emergency procedures.
  - Quality Assurance Program - description

#### Attachments:

- Standard Application Form - required
- Supplemental Form A – Facility Information - required
- Supplemental Form B – Unit Information and Certification - required

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

For assistance in applying for a permit, call 311.



## Instructions for Applying for a Health Department Linear Accelerator (LINAC) Permit

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

<b>Items Needed</b>  <i>Be sure the applicant's name is the same on all documents. See "Instructions for Completing an Application" for more details.</i>	<b>Legal Business Structure</b>		
	Individual	Partnership	Corporation or LLC
<b>Permit Application</b> <ul style="list-style-type: none"> <li>All applicable sections completed</li> <li>Supplemental Form(s) if applicable</li> <li>Signed by applicant (example: owner, officer, director or shareholder)</li> </ul>	✓	✓	✓
<b>Permit Fee</b> <ul style="list-style-type: none"> <li>See list of permit fees</li> <li>Credit card, money order or check payable to "DOHMH"</li> <li>Not-for-profits: no fee if proof of status is submitted (see below)</li> </ul>	✓	✓	✓
<b>Proof of Home Address</b> (one of the following) <ul style="list-style-type: none"> <li>Valid driver's license or non-driver ID</li> <li>Current lease or mortgage statement</li> <li>Utility bill, bank or credit card statement dated within the last 90 days</li> <li>"Affidavit of Home Address" form, completed by a person living with applicant and a recent utility bill or lease in that individual's name</li> </ul>	✓	✓ (needed for partnership of individuals only)	
<b>Photo Identification</b> One government-issued ID with photo, such as: <ul style="list-style-type: none"> <li>Driver's license or non-driver ID</li> <li>Alien Registration Card or Naturalization Certificate</li> <li>U.S. or foreign passport</li> </ul>	✓	✓	✓
<b>Proof of Sales Tax Collecting Authority</b> <ul style="list-style-type: none"> <li>Valid original NYS Certificate of Sales Tax Authority  <i>Obtain at <a href="http://www.nys-opal.com">http://www.nys-opal.com</a>. 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.</i></li> </ul>	✓	✓	✓
<b>Proof of Incorporation</b> <ul style="list-style-type: none"> <li>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.  <i>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.</i></li> </ul>		✓ (needed for partnership of corporations or LLCs only)	✓
<b>Workers' Compensation &amp; Disability Insurance Coverage</b> <ul style="list-style-type: none"> <li>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 <a href="http://www.wcb.ny.gov">http://www.wcb.ny.gov</a>.</li> <li>List DOHMH as the certificate holder (<b>not</b> the policy holder)</li> </ul>	✓	✓	✓
<b>Payment of Outstanding Fines for DOHMH Violations</b> (if any) <ul style="list-style-type: none"> <li><u>Certified</u> check, credit card or money order payable to "OATH Health Tribunal" (in person payment) or pay online with credit or debit card</li> </ul>	✓	✓	✓
<b>Proof of Not-for-Profit Status</b> (if applicable)* <ul style="list-style-type: none"> <li>Letter from the IRS stating not-for-profit status*</li> </ul>		✓	✓
<b>Power of Attorney or Authority to Act Affidavit</b> (if applicable) <ul style="list-style-type: none"> <li>If someone else will turn in the application for you</li> </ul>	✓	✓	✓



# Instructions for Applying for a Health Department Linear Accelerator (LINAC) 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, also 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



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

APPLICATION DATE		
MONTH	DAY	YEAR

NAME OF LICENSE/PERMIT  
 (For detailed instructions on what is needed to apply please go to Business Express at <http://www.nyc.gov/businessexpress>)

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

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

**This contact information will be used by the Department in the case of an emergency.**

**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		
DATE OF BIRTH (If applying as an individual)			MONTH	DAY	YEAR		OPTIONAL	
							GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female	
								What language do you speak? _____

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

**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

**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 MUST COMPLETE THE WORKERS' COMPENSATION AND DISABILITY BENEFITS INSURANCE INFORMATION REQUESTED BELOW **AND** PROVIDE COPIES OF PROOF OF CURRENT INSURANCE.

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

*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?  <input type="checkbox"/> YES <input type="checkbox"/> NO
	SIGNATURE OF BUSINESS OWNER, PARTNER, OR CORPORATE OFFICER  <b>SIGN HERE</b> ➤	

**IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO REGISTER TO VOTE HERE TODAY?**

YES  NO

Applying, or declining to apply, to register to vote will not affect the amount of assistance you will be provided by this agency. If you would like help in filling out the voter registration application, we will help you.

# APPLICATION FOR A LICENSE OR PERMIT Therapeutic Radiation (LINAC) Units



## Supplemental Form A – Facility Information

For detailed instructions on completing this form, refer to the *Guide for the Preparation of Registration for Therapeutic Radiation LINAC Units*

**1. Location where unit will be used or possessed:**

\_\_\_\_\_

Building Name

\_\_\_\_\_ (suite or room #)

Street Address

\_\_\_\_\_

Floor and Suite/Room Number

\_\_\_\_\_

City, State Zip Code

**2. Radiation Safety Officer:**

Name: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Telephone Number)

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Fax Number)

e-mail: \_\_\_\_\_

**3. Teletherapy Physicist:**

Name: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Telephone Number)

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Fax Number)

e-mail: \_\_\_\_\_

**4. Purpose for which the Therapeutic Radiation Unit will be used:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. Authorized Users**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Note: If there are additional users, please print below

# APPLICATION FOR A LICENSE OR PERMIT Therapeutic Radiation (LINAC) Units



## Supplemental Form B – Unit Information

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

Manufacturer's Name: _____		
Model Number: _____		
Does Unit Employ a Beam Stop? <input type="radio"/> Yes <input type="radio"/> No		
If Yes, is it: <input type="radio"/> Fixed <input type="radio"/> Removable		
<u>Electron Beam Energies:</u>	<u>Photon Beam Energies:</u>	<u>Maximum "beam on" radiation output at one meter for each radiation modality:</u>
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Equipment used to conduct radiation survey. Please list.			
Instrument	manufacturer	model	range

Dosimetry system equipment used to measure beam output. Please list.			
Instrument	manufacturer	model	volume

<p><b>Applicant must sign the following stipulation:</b></p> <p>The registrant agrees to conduct full calibration output measurements according to Task Group 21 Protocol 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 #40: Comprehensive Quality Assurance for Radiation Oncology.</p> <p>_____</p> <p>Signature</p>
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