O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a **license, permit or registration**, as referenced in O.C.G.A. § 50-36-1, from the **Department of Community Health, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1) _____ I am a United States citizen.

2) _____ I am a legal permanent resident of the United States.

3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as: _____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF _____, 20____

_____
NOTARY PUBLIC
My Commission Expires:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

David A. Cook, Commissioner *Nathan Deal, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

APPLICATION FOR X-RAY REGISTRATION

A. Applicant: _____ Facility _____
(Please Print or Type)

Facility Address: _____ Mailing Address: _____

_____

County: _____ Telephone ( ) _____ Fax ( ) _____

B. Has a Radiation Shielding Design for this facility been submitted to the X-ray Unit for approval: A plan must be submitted as part of the initial registration requirements: [ ] Yes [ ] No If yes, plan review no. _____

C. Is This Application for: (check all that apply)

[ ] A new facility
[ ] A purchase of new equipment
[ ] Relocation
[ ] Update information of Previously registered
[ ] Other _____

Have you previously registered an X-ray Facility in Georgia? [ ] Yes [ ] No
If yes, under what name: _____
_____
and in what county: _____

D. Equipment type: (Indicate the number of machines in each category):

____ 1 Dental Intraoral
_____ 2 Dental Cephalometric
_____ 3 Dental Panographic
_____ 4 Radiographic Only
_____ 5 Fluoroscopic Only
_____ 6 R & F Same Unit No of tubes ____
_____ 7 Mammography
_____ 8 C-Arm
_____ 9 Computerized Tomography
_____ 10 Photofluorographic
_____ 11 Analytical X-ray
_____ 12 Particle Analyzer
_____ 13 Therapeutic (less than 0.9 Mev)
_____ 14 Therapeutic Accelerator
_____ 15 Particle Accelerator
_____ 16 Cabinet X-ray
_____ 17 Open Beam X-ray
_____ 18 _____ Other
_____ 19 Bone Densitometer

E. Please check one in each category:

1. Practice

[ ] 1 Medical
[ ] 2 Dental
[ ] 3 Chiropractic
[ ] 4 Osteopathy
[ ] 5 Veterinary
[ ] 6 Podiatry
[ ] 7 Industrial
[ ] 8 Research
[ ] 9 Institution
[ ] 10 Other (Specify)

2. Facility Category

[ ] 1 Private Office
[ ] 2 Hospital
[ ] 3 Clinic
[ ] 4 Mobile (see F below)
[ ] 5 Education
[ ] 6 Industrial
[ ] 7 Institutional
[ ] 8 Specify _____

F. Van or Trailer I.D. No: _____ License Tag No. _____ Year: _____ State: ____

G. List all x-ray machines at the facility or in mobile van (Use additional sheets if necessary)

Console Brand Name _____ Model No._____ Serial No. _____

H. Install x-ray systems that have been disposed of during the last report period: Console Brand Name _____

Disposition_____ If sold, name _____

I. For diagnostic Facilities except hospitals; List all practitioners who have the authority to prescribe x-rays. Please Print.

J. Only the person responsible for radiation safety may sign (i.e. the doctor in charge or RSO)

_____
Authorized Signature/Title

_____
Print or Type Name

Date: _____

FOR DCH USE ONLY

Registration Number:

_____