# X-Ray Registration Form

Please include all the requested information and submit the completed form to Jill Robertson, Radiation Safety Manager (RSM):

**Email:** jrobertson@dal.ca  
**Fax:** 423-5242  
**Interdepartmental Mail:** Jill Robertson, Environmental Health & Safety Office, 1435 Seymour St., Halifax N.S.

*Please note, one form must be completed for each separate unit.*

| 1. Status | □ Existing  
□ New |
| --- | --- |
| 2. Location – *include all locations in which the device is used* | Campus:  
Building:  
Mobile unit: □ yes  
□ no  
Room(s): |
| 3. Use – *check all that apply and provide a brief description of use* | □ Dental (□ Cephalometric  
□ Intraoral  
□ Panoramic)  
□ Veterinary  
□ Analytical  
□ Cabinet  
□ Other: _____________________________  
Description: |
| 4. Device | Manufacturer:  
Model #:  
Serial #: |
| 5. Technical Factors | Maximum Rate: _____________kVp  
___________ mA |
<table>
<thead>
<tr>
<th></th>
<th>Principal Investigator (PI)</th>
<th>Email:</th>
<th>Phone:</th>
<th>netID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Secondary Contact</td>
<td>Email:</td>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

| 8 | Users – list all authorized users of this device | User(s): | Training Date on X-Ray Device: |

PI Signature __________________________ Date ______________

RSM Signature __________________________ Date ______________