Bureau of Radiological Health

Registration for Dental Radiation Machines

Please send the following items:

- Complete application
- Nonrefundable fee in a check or money order payable to Iowa Department of Public Health (IDPH)
- Completed equipment information
- The date(s) of your last equipment calibration

Mailing Address:
Iowa Department of Public Health
Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th Street
Des Moines, IA 50319

You can also complete the application online at https://idph.iowa.gov/regulatory-programs/radiation-machines

Customer Support phone: (855) 824-4357 Email: adperehreg@idph.iowa.gov

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FACILITY INFORMATION (Type or print the information below) ☐ **This is a new address.**

Facility Name: _____
Facility Contact Person: _____ Street Address: _____
City:_____ State: _____ Zip Code_____ Phone Number: _____
Email:_____ Registration Number (DENT1XXXX): _____
EIN/SSN _____ ☐ This is a new registration ☐ This is a renewal application

Type	Price ($)	Unit(s)	Total
Intraoral	60		
Panoramic/Cephalometric	60		
Cone Beam CT	60		
Hand Held	60		
Late Registration	$25/month		
Final Total Due			

Registration/Renewal: Please submit your application approximately **45 days before** your registration expired.

If your registration is **30 days** past due, please **add $25 per month** late fee to the total fees due.

Max fee for Dental is $3,000

AFFIRMATION QUESTIONS (*Required*)

These questions must be answered by sole proprietor applicants only. If you answer, "Yes" to any of the questions below (1) attach a signed letter explaining the details of the incident, including date(s), location(s), status, reason, etc. (2) attach a copy of any court ordered evaluations, showing completion & recommendations, and/or (3) attach a letter from a physician or treatment program for any medical condition(s).

(New) Do you have… **(Renewal)** During the previous licensing period, did you develop… a medical condition, which in any way currently impairs or limits your ability to perform the duties of this profession? Medical Condition means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.	☐ Yes ☐ No
(New) Have you, within the past 5 years… **(Renewal)** During the previous licensing period, did you… engage in illegal or improper use of drugs or other chemical substances?	☐ Yes ☐ No
(New) Have you ever been... **(Renewal)** During the previous licensing period, were you… convicted of a misdemeanor or felony crime? (You do not need to answer yes if your sole conviction or convictions are for minor traffic violations with fines under $250). In answering this question, note that a conviction means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. This means you must answer yes if a finding or verdict of guilt was returned against you in a criminal proceeding or if you plead guilty, entered a plea of nolo contendere, or entered an Alford plea in a criminal proceeding, even if the court expunged the matter or the court deferred judgment. You must submit the complaint and judgment of conviction for each offense.	☐ Yes ☐ No

These questions must be answered **by all applicants**. If you answer, "Yes" to any of the questions below (1) attach a signed letter explaining the details of the incident, including date(s), location(s), status, reason, etc. and/or (2) attach a copy of any court ordered evaluations, showing completion & recommendations,	
(New) Has**…** **(Renewal)** During the previous licensing period, did… any state or other jurisdiction of the United States or any other nation limit, restrict, warn, censure, place on probation, suspend, revoke, or otherwise discipline a professional license, permit, registration, or certification issued to you or your organization?	☐ Yes ☐ No
(New) Have there ever been… **(Renewal)** During the previous licensing period, were there… judgments or settlements paid on your or your organization behalf as a result of a professional liability case?	☐ Yes ☐ No
(New) Have you ever had**…** **(Renewal)** During the previous licensing period, did… a license, permit, registration, or certification denied, suspended, revoked, or otherwise disciplined by a certification body?	☐ Yes ☐ No

FACILITY DETAILS (*Required*)

Do you have a Radiation Protection Program that meets the parameters as outlined in IDPH guidance?	☐ Yes ☐ No
Is dosimetry issued to operators? If yes, Dosimetry Vendor name:_____	☐ Yes ☐ No
If no dosimetry is issued, I have documentation from a medical physicist or other personnel qualified to make the determination that no staff will exceed 10% of the annual 5 rem dose limit.	☐ Yes ☐ No
This facility has been previously registered to use radiation emitting equipment.	☐ Yes ☐ No
The licensed practitioner is the only operator of this x-ray equipment.	☐ Yes ☐ No
All radiation equipment operators have an Iowa permit to operate the equipment.	☐ Yes ☐ No
All radiation equipment operators are trained in safe operating procedures and are competent in the safe use of the radiation machine.	☐ Yes ☐ No
The facility has a method to log all x-ray exposures with the required information.	☐ Yes ☐ No
The facility will periodically review the exposure log for repeat trends and reinstruct staff accordingly.	☐ Yes ☐ No
Leaded aprons and gloves are available for use during x-ray procedures.	☐ Yes ☐ No
Are facility familiar with Image Gently/Image Wisely campaign advisements specific to the types of equipment your facility operates?	☐ Yes ☐ No

EQUIPMENT INFORMATION:

Mark the box(es) and fill in your equipment information below. If you are including copies of your most recent calibration reports and the information on the reports is accurate, you do not need to complete this section.

☐ Intraoral ☐ Panoramic/Cephalometric ☐ Cone Beam CT ☐ Hand Held

Is this a Mobile Unit? ☐ Yes ☐ No	Is this unit used outside your facility? ☐ Yes ☐ No
Machine Manufacture:	Machine Serial #:
Machine Model:	Room ID:
Manufacture Date:	Installation Date:
Date of current calibration or service evaluation report	

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DUPLICATE THIS PAGE AS NEEDED

MOBILE SITE INFORMATION: *(Complete only if you have mobile equipment used **outside** of the registered facility.)*

Site Name:
Address, City, State, Zip
Typical Schedule
Equipment Description

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Site Name:
Address, City, State, Zip
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Privacy Act Notice: Disclosure of your social security number on this application is required by 42 U.S.C. § 666(a) (13) and Iowa Code § 252J.8 (1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18. **NOTE:** This does not apply to facilities that have obtained an EIN, only to facilities under a Sole Proprietorship.

I am authorized to complete this application on behalf of the organization.

As representative of the organization, I hereby certify and declare under penalty of perjury that the information I provided in this document, including any attachments, is true and correct. As said representative of the organization, I am responsible for the accuracy of the information provided regardless of who completes and submits the application. I understand that providing false and misleading information in or concerning this application may be cause for disciplinary action, denial, revocation, and/or criminal prosecution. I also understand that a representative of the organization is responsible to update information submitted herewith if the response or the information changes.

In submitting this application, the organization agrees to any reasonable inquiry that may be necessary to verify or clarify the information provided on or in conjunction with this application.

I understand this information is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law.

I have read the Administrative Rules governing this license, permit, registration, or certification and will make employees aware as required and will comply with those provisions.

Required _____ _____

Signature of Organizational Representative **Date**

rev 6-May-21