Department Use Only
Registrant # _____
Account # _____
Staff initials _____
RADs entry date_____

NEW HAMPSHIRE RADIOLOGICAL HEALTH SECTION CERTIFICATE - DISPOSITION OR CHANGE OF OWNERSHIP OF RADIATION OR MRI MACHINE

REGISTRANT NAME *(Institution, firm, hospital, person, etc.)*	TELEPHONE NUMBER
SITE NAME *(If different from Registrant Name)*	SITE CONTACT *(Please Print)*
PHYSICAL ADDRESS	Site ID Number

NH Radiological Health Machine ID# _____ Machine Type _____

Manufacturer Name _____ Number of x-ray Tube Sources _____

Serial Number _____ Serial Number Location _____
(Control, HV Generator, other)

Please check appropriate box and provide information where applicable: *(Please provide details; e.g. name, date, etc.)*

Machine/X-ray tube source removed from facility/possession YES ☐ NO ☐ N/A ☐

☐ Machine was ***(select one)***: Sold ☐ Donated ☐ Ownership Transferred ☐

Name _____ Date: __/__/__

Address _____

_____

Telephone No. _____ Email _____

☐ Machine/X-ray tube source removed by Service Provider:

Name _____ Date: __/__/__

Address _____

_____

Telephone No. _____ Email _____

☐ Machine destroyed, taken to Transfer Station: _____ Date: __/__/__

☐ Machine relocated ***(select one)*:** In State ☐ Out-Of-State ☐ Date: __/__/__

Contact Name _____

Address _____

_____

☐ Machine placed in an "**in storage**" status, as defined in the NHRCR, part He-P 4040.12 Date: __/__/__

☐ Machine restored to service on: Date: __/__/__ Location/Room: _____

Attestation: I, the registrant or certifying officer signing on behalf of the registrant, understand and shall follow the relevant requirements of the NH Rules for the Control of Radiation (He-P 4000) and confirm that all of the information herein is complete and accurate.

_____ Date: __/__/__
Signature of Certifying Officer

_____
Printed Name of Certifying Officer

Please Remit Competed Form to the:
Department of Health and Human Services
Radiological Health Section
29 Hazen Drive
Concord, New Hampshire 03301-6503