



Bureau of Radiation Control, Radiation Machine Program
REPORT OF ASSEMBLY OF NON-CERTIFIED X-RAY SYSTEMS

Report of assembly of non-certified x-ray systems (i.e., not reported on FEDERAL FORM FD2579) is applicable to installations or acquisitions from sale, lease, transfer, relocation, or disposal of radiation machines and/or major components. Completing and filing this form to report the assembly or installation of an x-ray system or sub-system is required by State of Florida regulations. Any one engaged in the business of assembling, replacing, or installing one or more components into an x-ray system is considered an assembler and is subject to this requirement. This report MUST BE FILED WITHIN 15 DAYS following the assembly/installation.

**Bureau of Radiation Control, Radiation Machine Program
 705 Wells Rd Ste 300, Orange Park, Florida 32073
 Phone: (904)278-5730 Fax: (904)278-5737**

1. EQUIPMENT LOCATION		DH Registration JR-
a. Name of Hospital, Doctor, or Office where installed		
b. Street Address		
c. City		d. State
e. Zip Code	f. Telephone Number	

2. ASSEMBLER INFORMATION		DH Certificate V-
a. Company Name		
b. Street Address		
c. City		d. State
e. Zip Code	f. Telephone Number	

3. GENERAL INFORMATION

a. This report is for the assembly of components which are (check the appropriate boxes)

A complete x-ray system including an x-ray control, tube housing assembly, beam limiting device and x-ray generator.
 A replacement of one or more components in an existing system.
 An addition to an existing system.

b. Intended use(s) (check the applicable boxes)

<input type="checkbox"/> General Purpose Radiography	<input type="checkbox"/> Urology	<input type="checkbox"/> Head - Neck (Medical)
<input type="checkbox"/> General Purpose Fluoroscopy	<input type="checkbox"/> Mammography	<input type="checkbox"/> Dental - Intraoral
<input type="checkbox"/> Tomography	<input type="checkbox"/> Chest	<input type="checkbox"/> Dental - Cephalometric
<input type="checkbox"/> Angiography	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Radiation Therapy Simulator
<input type="checkbox"/> Podiatry	<input type="checkbox"/> Veterinary	<input type="checkbox"/> Other (Specify in comments section)

c. The X-ray System is (check one)
 Stationary Mobile

d. The Master Control is in Room

e. Date of Assembly

4. COMPONENT INFORMATION

a. The master control is A New Installation Existing Installation

b. Control Manufacturer

c. Control Model Number

D. Control Serial Number

e. Complete the following to list how many of each component was installed in this system using the appropriate box.

<input type="checkbox"/> Beam limiting device	<input type="checkbox"/> Table	<input type="checkbox"/> Tube Housing Assembly (medical)	<input type="checkbox"/> Spot Film Device
<input type="checkbox"/> X-ray control	<input type="checkbox"/> Cradle	<input type="checkbox"/> Dental Tube Head	<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> High voltage generator	<input type="checkbox"/> Film changer	_____	_____
<input type="checkbox"/> Vertical cassette holder	<input type="checkbox"/> Image intensifier	_____	_____

5. ASSEMBLER CERTIFICATION

I affirm all components assembled or installed by me for which this report is being made, were adjusted and tested by me according to the instructions provided by the manufacturer(s) and were installed in accordance with 404.22 Florida Statutes and the applicable regulations in the Florida Administrative Code.

a. Printed Name	b. Signature	c. Date
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6. COMMENTS