PROTECTIVE HEALTH SERVICES

Oklahoma State Department of Health
Protective Health Services / Consumer Health Service
Mail: PO Box 268815, Oklahoma City, OK 73126-8815
Physical: 1000 NE 10th St., Oklahoma City, OK 73117
Telephone: (405) 271-5243/ Fax: (405) 271-5286
Website: http://chs.health.ok.gov

DIAGNOSTIC X-RAY PERMIT APPLICATION FORM

Please check one: ☐ Initial Application ☐ Renewal Application

FACILITY FEE SCHEDULE 310:250-3-5: (Please check the appropriate facility type)					
☐ **Dental** ☐ **Podiatric**		☐ **Veterinary**		ALL Other: ☐ **Chiropractor;** ☐ **Clinic/Multi-Physician Office;** ☐ **Hospital;** ☐ **Physician office;** ☐ **Other: ______**	
Each Tube Fee:	$30.00	Each Tube Fee:	$25.00	Each Tube Fee:	$95.00

☐ Check ONLY if a State and/or Governmental Entity

TOTAL PERMIT FEE DUE (Send Check or Money Order ONLY to the PO Box listed above – Do NOT send cash – Credit Cards & Cash accepted by walk-in ONLY at 1000 NE 10th St in Oklahoma City)				
# of Tubes		**Tube Fee** ($30/$25/$95)		**TOTAL**
#______ List number* of tubes used at the facility/under this permit	x	$______ Type in appropriate tube fee from fee schedule checked above	=	$______ (Not to exceed $500)

*Facilities are permitted on the number of x-ray tubes in use. Please note, some x-ray units have two (2) tubes.

FACILITY INFORMATION

Facility Name: ________________________________ Total # of Tubes:__________

Location (Physical Address): ________________________________
Street Address/Finding Location

________________ ________ ________ __________
City State Zip County

CONTACT INFORMATION

Owner/Lessee Name: ________________________________

Mailing Address: ________________________________
Mailing Address

________________ ________ ________
City State Zip

Application Point of Contact Name: ________________ Primary Phone Number: ____________

Email Address: ________________________________

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OFFICIAL USE ONLY

TOTAL PAID:__________ RECEIPT NO.: ____________ REFERENCE NUMBER:____________

DESCRIPTION OF DIAGNOSTIC RADIATION PROCDUCING MACHINES

(Please complete this table for all machines currently in USE.)

Code of Machine IN USE*	Number of Tubes per Unit			Manufacturer	Model Number	Location within the Facility (i.e. Rm#)
	Fixed	Portable	Mobile			

*Code	Type of Machine	*Code	Type of Machine	*Code	Type of Machine
A ----	Bone Density	F ------	Cytoscopic	K------	Podiatry
B ----	C-arm	G------	Dental General	L ------	Radiographic (Human)
C ----	Cephlometric	H------	Flouroscopic (Human)	M -----	Veterinary (all types)
D ----	Computed Tomography (CT)	I-------	Mammography	O------	Other: ________________
E-----	Cone Beam CT	J ------	Panoramic		

(add a second page if needed)

HOURS OF OPERATION

(or times when staff are present to allow inspections outside of normal business hours)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open Time:							
Close Time:							
Other Time Description:							

Signature: ____ Date: ____________________

Owner/Lessee/Authorized Agent

Title of Authorized Signer: ___________________________________

(NOTE: Retain a copy of the completed form for your files.)