Ontario

Ministry of Health

Form 1 – X-ray Equipment Registration

☐ Existing Owner

☐ New Owner (No Registration Number)

MOH Facility Registration Number

Please use this number on all future correspondence.

Return completed and signed to:
E-mail: xris@ontario.ca (preferred)

Ministry of Health
X-ray Inspection Service
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5

Collection of the information on this form, including the applicant's name, address and X-ray equipment information, is authorized under the *Healing Arts Radiation Protection Act* (HARP), R.S.O. 1990, c.H-2, Section 4. For further details concerning collection of this information please contact: X-ray Inspection Service, 5700 Yonge Street, 5th Floor, Toronto ON M2M 4K5, Telephone number 416-327-7937.

1. Registration Required on (select one)

☐ New facility

☐ Transfer of Ownership (specify previous owner below)

☐ Existing facility ► ☐ Add new X-ray machine ☐ Remove existing X-ray machine ☐ Replace X-ray machine

Previous Owner (complete this portion only if Transfer of Ownership is selected)

Last Name	First Name	Registration Number

Have you attached a written notification of transfer of ownership from previous owner? ☐ Yes ☐ No

2. Current Owner of the X-ray Machine(s)

Facility/Operating Name

Corporate Name (if applicable)

Owner of X-ray Machine(s) at facility - Specify owner(s) if multiple owners or CEO/President if corporation

Last Name	First Name	Middle Initial

3. Radiation Protection Officer (RPO) for X-ray Facility Specified Below

☐ Same as Owner of the X-ray machine(s) in **Section 2**

Last Name	First Name	Telephone Number

RPO's Email Address

4. Type of X-ray Facility (select all that apply)

☐ Dental Facility
☐ Chiropractic Facility
☐ Podiatric Facility
☐ Hospital
☐ Correctional Centre
☐ Independent Health Facility (IHF) ►
☐ Mammographic Facility
☐ Ontario Breast Screening Program (OBSP)
☐ Postsecondary Institution or Career College
☐ Long-Term Care Facility
☐ Other (Specify)

IHF Billing Number	IHF Licence Number

5. Location of the X-ray Machine(s)

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MOH Facility Registration Number

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X-ray Facility Civic Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Contact Telephone Number ext.	Facility Email Address

6. List All X-ray Machines at the Facility

Type of X-ray Machine

Dental: **IOL** – Intra-oral; **PAN –** Panoramic; **CEP –** Cephalometric; **PCEP –** Combined Pan/Ceph; **DCT –** Dental Computerized Axial Tomography (e.g., CBCT, 3D); **ODEN** – Other Dental; **LT –** Linear Tomogram

Medical: **RAD** – Radiographic; **RAM –** Radiographic Mobile; **FLU** – Fluoroscopic; **MAM –** Mammographic; **CAT –** Computerized Axial Tomography; **BMD** – Bone Mineral Density; **RT –** Radiation Therapy; **FLM –** Fluoroscopic Mobile (e.g. c-arms, mini c-arms); **OMED** – Other Medical; **PI –** Podiatric-modified Intra-oral

X-ray Machine Make/Model	X-ray Machine Type (Enter code from table above)	Room Name as specified on Approved Installation Plan	Year of Installation (yyyy)
1.			
1.			
1.			
1.			
1.			
1.			
1.			
1.			
1.			
1.			

7. Additional X-ray Facilities

Does the owner also own, or own in partnership, X-ray machines at other locations?

☐ Yes (If Yes, complete section below)

☐ No

Facility Name	Facility Registration Number

Name(s) of Co-owner(s)

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

MOH Facility Registration Number

Please use this number on all future correspondence.

The owner undertakes to notify the Ministry within 15 days of changes of address or any other information given herein. Failure to do so is an offence under the HARP Act.

Submission Options (Choose one of the following options to submit this form)

Option 1: E-signature

☐ By checking this box and typing my name below, I certify that all information on this form is true and correct and that I am the owner or a delegate of the owner authorized to submit this form. I also agree that the checkbox and my name typed below are to be used as my electronic signature.

Title of Owner or Delegate	Last Name	First Name

Option 2: If you are signing a hard copy of this form, please scan and e-mail the signed form to the e-mail address provided at the beginning of this form.

Title of Owner or Delegate	Signature	Date (yyyy/mm/dd)