OUT OF STATE FACILITY REGISTRATION APPROVAL REQUEST

ENCLOSE THE FOLLOWING ITEMS WITH THIS FORM:

- ☐ Application Fee of $62.50 - ***This request cannot be processed without this fee*. (If paying by credit card, an invoice with instructions will be provided.)**
- ☐ Shielding Plan, if applicable-If shielding plan has already been accepted, log number(s): _____.
- ☐ If also submitting a shielding plan, include the shielding plan review fee of $62.50. **(If paying by credit card, an invoice with instructions will be provided.)**
- ☐ Operating Schedule.
- ☐ **Mammography facilities**: A copy of the mammography facility certificate issued by the FDA or another State, showing that the facility is currently certified.

**** All Sections of form must be completed or indicated as not applicable.**

Mammography Facilities:

Mammography facilities certified by another Certifying Agency (state or FDA) must have the following documentation available for review and inspection by the Department at all times while operating in South Carolina:

- ☐ A copy of the mammography facility certificate issued by the FDA or another State, showing that the facility is currently certified.
- ☐ A summary of the most recent physics survey of the mammography machine(s) and documentation of any corrective actions recommended by the medical physicist who performed the physics survey.
- ☐ Documentation that personnel meet the training and continuing experience requirements of MQSA. To include technologists, radiologists, and physicists.
- ☐ If self-referred patients will be accepted, then the facility must apply for Appendix A approval under SC regulations prior to providing services in the state of SC. Please contact this Department for more information.

Facility Information:

Facility Name: _____

Correspondence Address: _____

_____

Give full names of partners, co-owners, etc. (if applicable):_____

_____

If there are Corporate owners, give full name of Corporation, etc. (if applicable): _____

_____

Facility Contact:

Name and Title: _____

Mailing Address: _____

_____

Phone number: _____ Fax number: _____

E-mail:_____

DHEC USE ONLY: Registration #_____Check/Invoice #_____Amount $_____

Billing Contact:

Name and Title: _____

Mailing Address: _____

_____

Phone number: _____ Fax number: _____

E-mail: _____

Radiation Safety Officer (RSO)

Name and Title: _____

Mailing Address: _____

_____

Phone number: _____ Fax number: _____

E-mail: _____

Qualifications of RSO: _____

List all Licensed Practitioners (who will order and/or read at this facility), with license numbers (All License #'s will be verified):

Name	License #	Name	License #

For more information regarding licensing in South Carolina, please refer to: http://www.llr.state.sc.us/.

For Medical/Mammography facilities: Per Title B regulations, operators must hold a valid certificate issued by the South Carolina Radiation Quality Standards Association (SCRQSA). Contact the SCRQSA (https://www.scrqsa.org/) for more information regarding these certificates.

Name	License #	Name	License #

Equipment Type (refer to list on instructions page; list all that apply): _____

_____

_____

Facility Type (refer to list on instructions page): _____

Installation Type (truck, van, etc.): _____

Digital: Yes □ or N o □

Shielding Plan log #, if applicable _____

If the unit is installed in a truck, van, etc., then also include a copy of the radiation area survey.

Operating Schedule:

No person shall bring any radiation machine into the state, for any temporary use, unless such person has given written notice to the agency at least five (5) working days before the machine is to be used in the state. This notice must include the type of radiation machine/ the nature, duration, and scope of use; and the exact location(s) where the radiation machine is to be used. This notice must be provided on form DHEC 0461 Operating Schedule – Out of State X-ray Facilities. This form can be found here: https://scdhec.gov/sites/default/files/Library/D-0461.pdf

This notice may be submitted by mail at SCDHEC - Bureau of Radiological Health - X-ray, 2600 Bull Street, Columbia, SC 29201. Or by FAX at (803) 545-4412. This notice shall be submitted on form number DHEC 0461.

Signature of RSO: _____

This request cannot be processed without the signature of the RSO.

Printed name of RSO: _____

Please Return To:
S.C. Department of Health and Environmental Control
Bureau of Radiological Health
X-ray Facility Registration
2600 Bull Street
Columbia, SC 29201
(803) 545-4400 FAX (803) 545-4412

S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL BUREAU OF RADIOLOGICAL HEALTH
FACILITY REGISTRATION APPROVAL REQUEST

PURPOSE:

This form is for the Out-of-State Facility Registration Approval Request. Any facility planning to bring an x-ray producing machine into South Carolina for use shall apply for and receive an Out-of-State Facility Registration Approval prior to operation of the x-ray machine in South Carolina.

ITEM BY ITEM INSTRUCTIONS:

Enclose the Following Items with this Form – Indicate by checking the items enclosed with this form.

Facility Name – This refers to the person or company planning to operate an x-ray producing machine in South Carolina.
Correspondence Address – Give the address where the correspondence should be sent.
Names of partners, co-owners, etc. – Full names of partners, co-owners, etc. if applicable.
Name of Corporate owner, if applicable.

Facility Contact Name and title – The person responsible for the submission of this request.
Mailing Address – Self-explanatory.
Phone Number – Self-explanatory.
Fax Number – Self-explanatory.
E-mail – Self-explanatory.

Billing Contact Name and title – The person responsible for the payment of bills.
Mailing Address – Self-explanatory.
Phone Number – Self-explanatory.
Fax Number – Self-explanatory.
E-mail – Self-explanatory.

Radiation Safety Officer (RSO) – Give the name of the person who will be responsible for radiation protection at the facility.
Mailing Address – Self-explanatory.
Phone Number – Self-explanatory.
Fax Number – Self-explanatory.
E-mail – Self-explanatory.
Qualifications of RSO – List the qualification/training of the RSO.

Doctors at the facility - Give the name and SC license number of each doctor who will order and/or read at this facility.

Operators of the x-ray equipment – Give the name and SCRQSA license number for each operator who will operate in South Carolina.

Equipment Type – Indicate the equipment type using the list below.
Facility Type – Indicate the facility type using the list below.
Digital – Circle Yes or No.
Shielding Plan log # (if applicable) – Give the log # of the accepted shielding plan.

Fax Number – Self-explanatory.
Contact name and title – Contact person name and title for installation vendor.
E-mail – Self-explanatory.

Signature of RSO – Must be signed by the RSO.
Printed name of RSO – Must be legibly printed.

OFFICE MECHANICS AND FILING:

When the FRA request forms are received, stamp the form and all attachments with the date received. After review and approval, the form and all attachments are placed into the registrant's file, and the FRA approval is returned to the registrant for their records. The retention schedule series for this form is 11908- X-Ray Files and/or 16470 Mammography Files. These forms are maintained in facility files and purged 3 years after the termination of the facility.

Type of Facility

Academic	Analytical/Industrial	Chiropractic	Dental
Hospital	Medical	Podiatry	Prison
Radiation Therapy	Security	Veterinarian	Other (Specify)

Type of Equipment

Accelerator (Non-human use)	Baggage Checker	Breast CT	Bone Densitometer
Cabinet x-ray	C-arm fluoroscopic	Cephlometric	Ceph/Dental
Combination (Rad/Fluoro)	CT Scanner	CT Simulator	Dental (Intraoral)
Dental CT	Diffraction	Electron Microscope	Fluoroscopic
Lithotripter	Mammography	O-arm	Panoramic
PET/CT Scanner	Radiographic	Simulator	Shielded Room (Radiographic)
Spectograph	SPECT/CT Scanner	Stereotactic	Therapy (Accelerator human use)
X-ray Fluorescence	X-ray Gauge	Other (Specify)	