OKLAHOMA State Department of Health

Oklahoma State Department of Health
Consumer Health Service
PO Box 268815, Oklahoma City, OK 73126-8815
Telephone: 405.426.8250 Fax: 405.900.7557
Website: Oklahoma.gov/health/CHS

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 123 Robert S. Kerr Ave. 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.)