

1. Business name of machine owner _____

2. Business address of machine owner _____

3. Location of Machine, Room #, Vault # _____

The owner will notify the Radiation Protection Division of any new or change in equipment, its use or location, **PRIOR TO** such change. Mail to: Radiation Protection CancerCare Manitoba, 675 McDermot Avenue, Winnipeg, Manitoba, R3E 0V9, Ph. (204) 787-4145, Fax (204) 775-1684.

4. Nature of machine use (check where applicable)

- Diagnostic Type: _____ Industry Research
 Therapy Type: _____ Veterinary Dental

5. RED Act Compliant: Yes No CSA or Equivalent Approved: Yes No Type _____

Medical Device Licence: Yes No

MDL Licence No.(Generator) _____ MDL Licence No.(Tube) _____

(Note: Checking the "Yes" box indicates that you are aware of the Medical Device Licence Regulation)

6. Machine Type:

- Stationary Mobile Portable Handheld

7. Is this machine a replacement? Yes No If "Yes", please indicate machine being replaced:

Make _____ Model _____ CancerCare Registration Number _____

8. _____

Component Description	Generator	X-Ray Tube Housing	X-Ray Tube Insert	Fluoroscopic Tube Housing	Fluoroscopic Tube Insert
a) Manufacturer					
b) Model Name					
c) Model Number					
d) Serial Number					
e) Supplier					
f) Energy					
g) Manufacture Date					

9. Registered Owner of Equipment Appointed Radiation Safety Person/Contact Person

Name _____	Name _____
Date _____	Title _____
Signature _____	Phone _____
	Date _____
	Signature _____

THE REGISTRATION OF THIS EQUIPMENT DOES NOT IMPLY APPROVAL FOR ITS OPERATION

10. OFFICIAL USE ONLY			
Date Received	Date returned	Reviewed by	Registration number