



Creating a State of Health

PROTECTIVE HEALTH SERVICES

Oklahoma State Department of Health
Consumer Protection
PO Box 268815
OKC, OK 73126-8815
Telephone: (405) 271-5243
FAX: (405) 271-3458

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)

<input type="checkbox"/> Dental <input type="checkbox"/> Podiatric		<input type="checkbox"/> Veterinary		ALL Other: <input type="checkbox"/> Chiropractor; <input type="checkbox"/> Clinic/Multi-Physician Office; <input type="checkbox"/> Hospital; <input type="checkbox"/> Physician office; <input type="checkbox"/> Other: _____	
FIRST Tube Fee:	\$40.00	FIRST Tube Fee:	\$30.00	FIRST Tube Fee:	\$100.00
Each Additional Tube Fee:	\$25.00	Each Additional Tube Fee:	\$20.00	Each Additional Tube Fee:	\$90.00

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)

INITIAL Tube Fee (\$40/\$30/\$100)	# of ADDITIONAL Tubes	ADDITIONAL Tube Fee (\$25/\$20/\$90)	TOTAL
\$ _____	# _____	\$ _____	\$ _____
Type in appropriate FIRST tube fee from the fee schedule checked above	+ List number* of ADDITIONAL tubes used at the facility/under this permit (do not include the first tube)	x Type in appropriate ADDITIONAL 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: _____

OFFICIAL USE ONLY

TOTAL PAID: _____ RECEIPT NO.: _____ REFERENCE NUMBER: _____

DESCRIPTION OF DIAGNOSTIC RADIATION PRODUCING 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 ---- Cephalometric | H----- Flourosopic (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.)