NYC Department of Health and Mental Hygiene

OFFICE OF RADIOLOGICAL HEALTH

Cancellation of Registration Form

INSTRUCTIONS: **Print or type all information.** Please sign (required) and return the completed form.

1. Facility Registration Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

2. Facility Information

Facility Name ____________________

Address ____________________

City, State, Zip ____________________

Number and Type of Units on Site:

A. __Dental/CBCT/Hand-held
B. __Radiographic Fixed/Mobile
C. __Fluoroscopic C-Arm Fixed/Mobile
D. __Comb R&F
E. __CT Scanner/PetCT
F. ___Bone Densitometer
G. __ Mammography
H. __Stereotactic Breast Biopsy
I. ___Medical Accelerator/OBI
J. ___ Therapy(0 KVP-1MV)Blachy Therapy
K. ___ Non-Medical Electron Microscope
L. ___ Non-Medical X-ray Diffraction
M. ___ Non-Medical Particle Accelerator
N. ___Non-Medical Gauge or Screening
O. ___ Non-Medical Industrial Radiography
P. ___ Non-Medical XRF
Q. ___ Other ____________________

3. Current Status of Equipment:

A. Has equipment been taken to new location? ☐ Yes ☐ No
If **no**, complete B, C, and D below:

If yes, address and phone of new location: ____________________

____

Phone (____)______-____________________

B. Has equipment been sold? Yes ☐ No ☐ If yes, date of sale:_____/____/ ______
Month Day Year

Name of new owner: ____________________

Address:____________________

____

Phone: ____________________

C. Has equipment been disassembled or scrapped? ☐ Yes ☐ No
If yes, give date:______/______/ ______
Month Day Year

D. Is equipment currently in use? ☐ Yes ☐ No
Date stop using equipment:______/______/ ______
Month Day Year

4. By signature below, I request that my registration be cancelled:

Signature ____________________

Print Name____________________ Title___________Date___________

Return by email to: ORH@health.nyc.gov or fax to: 718-310-2888
Questions? Call 718-310-2840