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: / / Year
   Name of new owner: ________________________________
   Address: __________________________________________
   Phone: ____________________________________________

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

D. Is equipment currently in use?  
   Yes [ ] No [ ]
   Date stop using equipment: / / Year
   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