



New Jersey Department of Environmental Protection
Bureau of X-Ray Compliance
Radiation-Producing Machine Registration Application

Facility ID: _____ Registration Number: _____

The Bureau issues the numbers for new facilities and all registrations.

New Facility Existing Facility-New Machine Temporary Registration (Start Date _____)

Amended Registration Reason: We've Moved New Owner Machine Information (Section 6)

IMPORTANT: Both pages MUST BE COMPLETED when registering or modifying a machine registration.

1. FACILITY INFORMATION (Please print/type all information).

Facility Name _____
Facility Contact _____
Physical Address _____ Suite # _____
City _____ ST _____ Zip Code+4 _____ + _____ County _____

2. BILLING/MAILING ADDRESS (If different from item 1)

Mailing address _____ PO Box _____ Suite # _____
City _____ ST _____ Zip Code+4 _____ + _____ County _____

3. OWNER or RESPONSIBLE PARTY

Owner Name _____ First _____ MI _____ Last _____ Title (MD, DDS, DVM, etc) _____
Phone Number _____ EXT _____ Fax Number _____
Business E-mail _____
Discipline: Industrial Medical Dentist Chiropractor Podiatrist
Veterinarian Hospital School Government

4. MOBILE/MOTOR VEHICLE/TRAILER FACILITIES (only for equipment permanently mounted in vehicle)

Vehicle Information: Year _____ Make _____ Model _____
State: _____ Plate # _____ Vin # _____
Please enclose a copy of your vehicle registration.

5. REGULATORY REQUIREMENTS

- 1. The New Jersey Administrative Code (N.J.A.C.) 7:28-3.1(b) requires all owners of x-ray equipment to register equipment within 30 days of acquisition.
2. Please see N.J.A.C. 7:28 et seq. for regulations regarding radiation safety surveys of the environs (www.xray.nj.gov); Rules and Regulations

Mail completed forms to BXC, PO Box 420, Mail Code 25-01, Trenton, New Jersey 08625-0420 or

Submit PDF forms to BXC@dep.nj.gov

Phone: 609-984-5463

Fax: 609-984-5811

Website: www.xray.nj.gov



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6. MACHINE INFORMATION

Machine Category _____ Fee schedule location: http://www.state.nj.us/dep/rpp/reg/fees.htm
Date Acquired ____/____/____ Manufacturer _____
Model Name _____ Generator Model No.* _____
Generator Serial No.* _____ Tube Insert Serial No. _____
Date Manufactured _____ Location (Room ID) if applicable _____
Max kVp _____ Max mA _____ Max MeV _____ (therapy and industrial units only)

*Generator Model and Serial No. changes require a new registration form and radiation survey.

7. IMAGE RECEPTOR (Must check one)

DR - Digital Radiography CR/PSP- Computed Radiography/ Photo Stimulable Phosphor
Film - Automatic processing Film - Manual processing No film (Industrial x-ray units)

IMPORTANT Do NOT send check with registration application.
You will receive an invoice after the equipment has been registered.

8. SIGNATURE

Print Name (Owner or Responsible Party) _____ Title _____
Signature (Owner or Responsible Party) _____ Date _____

For Bureau Use Only

Date Received _____ Date Returned _____

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All registration forms are two pages. Please complete both pages, sign and send to BXC.