2005 *Public Health Act*
Radiation Safety Regulations

SCHEDULE 1

APPLICATION FOR OWNERSHIP REGISTRATION OF RADIATION EQUIPMENT

DEPARTMENT OF HEALTH

Name of Owner or Institution_____

Address _____ Telephone_____ _____

Location of Device, If different from above _____

TYPE OF DEVICE (CHECK APPROPRIATE (√) - MAY CHECK MORE THAN ONE BOX)

☐ General Radiography (Medical)
☐ Fluoroscopy (Medical)
☐ Mobile
☐ Special Procedures (Medical)
☐ Therapy
☐ Others (Specify)

☐ Dental
☐ Chiropractic
☐ Veterinarian
☐ Research (Medical or Other)
☐ Industrial (All Types Other Than A, E, C, B. Licensed)

Please list each piece of radiation equipment:_____
_____
_____
(Use Additional Sheet if necessary)

MAKE	MODEL AND SERIAL NUMBER

The number of radiation workers employed at this location: _____

The Owner must notify the Department of Health of any changes in the information given herein.

Date At _____ This _____ Day of _____, 20 _____.

Signature of Owner _____

Return completed form to:

Department of Health
PO Box 2000
Charlottetown, PE CIA 7N8
Fax: 902-368-6468

EC621/05