| FOR OFFICE USE ONLY (DATE RECEIVED) | **COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT**<br>HMWMD - X-Ray Certification Program<br>4300 Cherry Creek Drive South, B1<br>DENVER, COLORADO 80246-1530<br>(303) 692-3448 or 3443 FAX (303) 691-7841<br>**REPORT OF ASSEMBLY OF A DIAGNOSTIC X-RAY SYSTEM** | **CDPHE - FORM 2579** |
|---|---|---|

## 1. EQUIPMENT LOCATION

| a. NAME OF HOSPITAL, DOCTOR OR OFFICE WHERE INSTALLED | | |
|---|---|---|
| **COLORADO FACILITY REGISTRATION NO.:** | | |
| b. STREET ADDRESS | | |
| c. CITY | d. STATE | |
| e. ZIPCODE | f. TELEPHONE NUMBER | |

## 2. ASSEMBLER INFORMATION

| a. COMPANY NAME | | |
|---|---|---|
| **COLORADO SERVICE COMPANY REGISTRATION NO.:** | | |
| b. STREET ADDRESS | | |
| c. CITY | d. STATE | |
| e. ZIP CODE | f. TELEPHONE NUMBER | |

## 3. GENERAL INFORMATION

a. THIS REPORT IS FOR ASSEMBLY OF CERTIFIED COMPONENTS WHICH ARE (CHECK APPROPRIATE BOX(ES))

- ☐ NEW ASSEMBLY - FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY - FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY - MIXED SYSTEM (Both certified and uncertified components)
- ☐ NEW ASSEMBLY - MIXED/UNCERTIFIED
- ☐ REPLACEMENT COMPONENTS IN AN EXISTING SYSTEM
- ☐ AN ADDITION TO AN EXISTING SYSTEM

b. INTENDED USE(S) (Check Applicable Box(es))

- ☐ GENERAL PURPOSE RADIOGRAPHY
- ☐ GENERAL PURPOSE FLUOROSCOPY
- ☐ TOMOGRAPHY (OTHER THAN CT)
- ☐ ANGIOGRAPHY
- ☐ PODIATRY
- ☐ VETERINARIAN
- ☐ UROLOGY
- ☐ MAMMOGRAPHY
- ☐ CHEST
- ☐ CHIROPRACTIC
- ☐ CT HEAD SCANNER
- ☐ CT WHOLE BODY SCANNER
- ☐ HEAD - NECK (MEDICAL)
- ☐ DENTAL - INTRA0RAL
- ☐ DENTAL – CEPHALOMETRIC
- ☐ DENTAL PANORAMIC
- ☐ RADIATION THERAPY SIMULATOR
- ☐ C-ARM FLUOROSCOPIC
- ☐ INDUSTRIAL / SECURITY
- ☐ BONE MINERAL ANALYSIS
- ☐ OTHER (Specify in Comments)

| c. THE X-RAY SYSTEM IS (Check one)<br>☐ STATIONARY ☐ PORTABLE (HANDHELD)<br>☐ MOBILE | d. STATE OF COLO. BLUE LABEL NUMBER (IF ON MACHINE) | e. DATE OF ASSEMBLY<br>_____/_____/_____<br>(MM) (DD) (YYYY) |
|---|---|---|

## 4. COMPONENT INFORMATION

**IF THIS IS THE REPLACEMENT OF A COMPONENT, INDICATE OLD MODEL & SERIAL NUMBER AND BLUE CDPHE CERTIFICATION LABEL NUMBER IN COMMENTS BELOW**

| a. THE MASTER CONTROL IS<br>☐ A NEW INSTALLATION<br>☐ EXISTING (Certified)<br>☐ EXISTING (Non-certified) | b. CONTROL MANUFACTURER | d. CONTROL SERIAL NUMBER | e. DATE MANUFACTURED |
|---|---|---|---|
| | c. CONTROL MODEL NUMBER | f. SYSTEM MODEL NAME (CT Systems Only) | |

Complete the following information for the certified components listed below which you installed. For beam limiting devices, tables and CT gantries enter the manufacturer and Model number in the indicated spaces. For other certified components, enter in the appropriate blocks how many of each you installed in this system.

| | g. SELECTED COMPONENTS | | | h. OTHER CERTIFIED COMPONENTS (Enter number of each installed in appropriate blocks) | |
|---|---|---|---|---|---|
| BEAM LIMITING DEVICES | MANUFACTURER | MODEL NUMBER | DATE MANUFACTURED | ☐ X-RAY CONTROL | ☐ CRADLE |
| | MANUFACTURER | MODEL NUMBER | DATE MANUFACTURED | ☐ HIGH VOLTAGE GENERATOR | ☐ FILM CHANGER |
| TABLES | MANUFACTURER | MODEL NUMBER | DATE MANUFACTURED | ☐ VERTICAL CASSETE HOLDER | ☐ IMAGE INTENSIFIER |
| | MANUFACTURER | MODEL NUMBER | DATE MANUFACTURED | ☐ TUBE HOUSING ASSEMBLY | ☐ SPOT FILM DEVICE |
| CT GANTRY | MANUFACTURER | MODEL NUMBER | DATE MANUFACTURED | ☐ DENTAL TUBE HEAD | ☐ OTHER (Specify) |

## 5. ASSEMBLER CERTIFICATION

I affirm that all certified components assembled or installed by me, for which this report is being made, were adjusted and tested by me according to the instructions provided by the manufacture(s), were of the type required by the manufacturer(s), were of the type require by the diagnostic x-ray performance standard (21 CFR Part 1020), were not modified to adversely affect performance, and were installed in accordance with provisions of 21 CFR Part 1020. I also affirm that all instruction manuals and other information required by 21 CFR Part 1020 for this assembly and a copy of this form have been furnished to the purchaser and within 15 days from the date of assembly, a copy of this report will be distributed to the Colorado Department of Public Health and Environment, X-Ray Certification Unit.

| a. PRINTED NAME | b. SIGNATURE | c. DATE |
|---|---|---|
| | | |

**6. COMMENTS (NOTE: Colorado Regulations require that the Assembler verifies the facility has a Shielding Design completed (when required) and the component(s) were installed according to the area diagram approved in the Shielding Design) SHIELDING DESIGN VERIFIED: YES NO N/A**

**7. DOES THE WORK YOU PERFORMED TODAY REQUIRE AN EVALUATION BY A CERTIFIED INSPECTOR? YES NO**

**PLEASE LEAVE COPY OF FORM WITH FACLITY**

**FORM CAN BE SUBMITTED VIA HTTP://CDPHE- CDPHE_XRAY_QISC@STATE.CO.US**