State of Colorado
Department of Public Health & Environment
Application for Healing Arts Screening

INSTRUCTIONS: This application must be printed in ink. Please provide all information requested on this form. This form and copies of this form must have original signatures and dates. Mail original or email copies with all attachments to the **Colorado Department of Public Health and Environment, HMWMD Radiation Control Program, X-Ray Certification Unit RM-B2, 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530. Email forms to: cdphe.hmxraycomments@state.co.us.** Please retain a copy of this application form for your records. All Healing Arts approvals are issued in accordance with the requirements contained in the Colorado Department of Public Health and Environment, *Rules and Regulations Pertaining to Radiation Control*, 6 CCR 1007-1, Part 6, Appendix 6F. If additional information is required to complete this form, please call (303) 692-3448 or (888) 569-1831 toll-free (outside the 303 area code), or fax (303) 691-7841 Attention: X-Ray Certification Unit.

Below, complete all items of the application as appropriate.

Application Date: _____ **Facility Registration #: _____**	**Application Category** (check one): **_____New Application** **_____Renewal Application** **_____Information Update** **_____Other**

Application Information:

Applicants Name or Business Name: _____

Mailing Address:_____

City:_____ State:_____Zip Code**:**_____

Administrator's Name (most responsible individual) **:**_____ **Phone** Number: **( )**_____

Location Street Address: (____Same as mailing address) complete if different

Location Address:_____

City:_____ State**:**_____Zip Code:_____

FAX Phone Number: **( )**_____ **_____No Fax Machine**

Email Address:_____

Screening Procedure

_____ CT Cardiac Screening _____CT Colon Screening _____CT Lung Screening _____Other (State type of Healing Arts):_____

_____Bone Density _____Fluoroscopy _____ Research (State type of research): _____

Additional Comments:

List equipment used for this Healing Arts Screening (equipment manufacturer, model number, serial number)

Description of x-ray procedure performed for this Healing Arts Screening Program (Give the Protocol)

State Certification Label Number (include expirations date):_____

Name of Registered Medical Physicist/Qualified Inspector:_____

For Office Use Only

Approval Review/Recommendations:

_____Approval _____Denial

Signature of Reviewer:_____Date:_____Title:_____

Signature of Unit Leader:_____Date:_____Title:_____

Signature of Administrative Staff:_____Date:_____Title:_____Date of Completion/Mailing:_____

Comments: (If approval is denied, substantiate with a brief statement and make recommendations if further action is required:

List any quality control procedures for equipment and/or image processing and the frequency of these procedures:

Describe the procedures for retention or disposition or radiographs and other records if applicable;

Name of Service Provider:

Other Miscellaneous Information:
Is there a **Shielding Design Analysis** on file at the facility? (If applicable) _____YES _____NO

Name of Registered Medical Physicist who performed Shielding Analysis:_____

Is there a copy of the **ALARA** policy and procedure on file at this facility? _____YES _____NO

Other Applicable Comments:

Description of Population Receiving Health Screening Procedure

Age distribution of population to be screened:
_____Male _____Female _____Other (Specify)

Patient's physical condition or disease process to be ruled out: (Disease or conditions for why procedure is being performed)

Frequency of x-ray screening procedure if any:

Estimate of total radiation dose for the screening procedure:

Description of how patient/private practitioner will receive results if further medical needs are indicated:

List any alternative methods not involving ionizing radiation that could achieve the goals of this screening procedure:

Physician Information

List radiologist/physician/practitioner interpreting the images:

Radiologist/physician/practitioner address:

Current license for each interpreting radiologist/physician/practitioner: (Attach copies to this application)

Copy of prescribed order by a licensed practitioner for the screening procedure: (Attach copy of the standing order with this application)

Operator Information

Name of supervising operator/manager of facility:

Supervisor/Manager address:

Name and Credentials of all operators performing the screening procedure: (Attach copies of credentials to this application)

Documentation for all operators to include: a. Adequate Radiation Safety Training b. Copies of most recent personnel radiation dosimetry reports

As owner/registrant, "I, _____, the undersigned owner/registrant, certify that: I have personally examined and am familiar with the information contained in this application for Healing Arts Screening request; the information contained in this application request is to the best of my knowledge, true, accurate, and complete in all respects; and I am fully authorized to make this Healing Arts Screening request on behalf of this facility and agree to keep this request on file with the formal written notification of the approved Healing Arts Screening request by the Department.

Signature of owner/registrant:_____Date:_____