MDH Minnesota Department *of* Health

(MDH Use Only)
Service Provider #:

Service Provider Registration Application

Applicant Information

Name: _____
First Middle Initial Last

Home Address: _____

City/State/Zip: _____

Phone #: _____ Email: _____

Employment Information

Company Name: _____

Business Address: _____

City/State/Zip: _____

Business Phone #: _____ Fax #: _____

Experience and Training

Experience (Please check all that apply. Use additional paper if necessary.)

Years of Experience _____

☐ Automatic Processors	☐ Bone Densitometry	☐ C-arms	☐ Computed Radiography
☐ CT Installation	☐ CT Physics Testing	☐ Dental Extraoral	☐ Dental Intraoral
☐ Digital	☐ Fluoroscopic	☐ Industrial	☐ Mammographic
☐ Podiatry	☐ Radiographic	☐ Other (list) _____	

Training (List specific training, providers and dates. If checking CT Physics Testing, include copies of all training with application. Use additional paper if necessary.)

_____

_____

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_____

Manufacturers

☐ Agfa	☐ Axtech	☐ Belmont	☐ Bennett	☐ Continental
☐ CPI	☐ Del Medical	☐ Excel	☐ Fischer	☐ Gendex
☐ General Electric	☐ Hologic	☐ Icat/New Tome CT	☐ Instrumentarium	☐ Kodak
☐ Konica	☐ Lorad	☐ Lumix	☐ Midwest	☐ Mini X-ray
☐ Norland	☐ OEC	☐ Phillips	☐ Picker	☐ Planmeca
☐ Prodigy	☐ Progeny	☐ Quantum	☐ Ritter	☐ Schick
☐ Sedecal	☐ Siemens	☐ Sirona	☐ SS White	☐ Summit
☐ Toshiba	☐ Traceray	☐ Transworld	☐ Universal	☐ Weber

☐ Other (list) _____

Services

☐ Diagnostic
☐ Equipment Performance Evaluations
☐ Industrial
☐ Installation Calibration
☐ Installation of Equipment
☐ Quality Control Tests
☐ Repairing of Equipment
☐ Shielding Plans
☐ Verification Tests
☐ Other (list) _____

Signature

I declare that all the information I have provided is true and complete and that I have read and understand the department's "Tennessen Warning." We are requesting your name, address and phone number so that we may contact you for further information relating to your service provider registration and renewal. You are not required to provide this information. However, without it we will not be able to contact you regarding additional information that may be needed or for renewal of the registration. All information you provide is legally classified as confidential data for individuals and can only be released to Minnesota Department of Health employees as needed to process renewal registration and anyone having a court order to obtain the information.

Applicant Signature _____ Date _____

Before submitting the application, be sure to:

1. Fill out all applicable sections of the application.
2. Include email address.
3. Sign and date the application.

Submit To: Minnesota Department of Health
Radiation Control, X-ray Unit
625 Robert Street North
PO Box 64975
St. Paul, MN 55164-0975
Fax: 651-201-4606
health.xray@state.mn.us

03/15/16