



**NORTH DAKOTA DEPARTMENT OF HEALTH
RADIATION CONTROL PROGRAM
ASSEMBLER REGISTRATION**

NOTE: See instructions on reverse side. Registration does not imply approval or disapproval of this assembler, nor is it a license.

COMPANY NAME _____
 ADDRESS: _____
 CITY: _____ STATE _____ ZIP: _____
 PHONE NUMBER: _____

TYPE OF SERVICE

- | | | | |
|------------|--------------------------|-------------------------------------|--------------------------|
| MEDICAL | <input type="checkbox"/> | SALES AND SERVICE | <input type="checkbox"/> |
| DENTAL | <input type="checkbox"/> | SERVICE AND INSTALLATION | <input type="checkbox"/> |
| INDUSTRIAL | <input type="checkbox"/> | SALES DEMONSTRATIONS | <input type="checkbox"/> |
| | | CONDUCTING RADIATION TRAINING | <input type="checkbox"/> |
| | | COMBINED SALES/SERVICE/INSTALLATION | <input type="checkbox"/> |

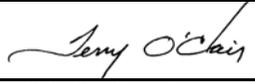
North Dakota Radiological Health Rules - Chapter 33-10-02, "Registration of Radiation Machine Facilities and Services," provides for the registration of persons providing radiation machine installation, servicing, or service.

I (We) have reviewed Chapter 33-10-02 relating to our type of services. By submitting this registration, I (We) agree to comply with the provisions of the North Dakota Radiological Health Rules.

NAME: _____

SIGNATURE: _____ DATE: _____

Please check if requesting a copy of the North Dakota Radiological Health Rules.

<small>DO NOT WRITE IN THIS SPACE - FOR OFFICE USE ONLY REGISTRATION CERTIFIED NORTH DAKOTA DEPARTMENT OF HEALTH</small>
Registration Number: _____
Division Director 
<small>By (James Lawson/ Warren Freier/ Dan Harman)</small>

INSTRUCTIONS FOR COMPLETING REGISTRATION FORM

ITEM	INSTRUCTIONS
Company Name	Print/type name of the company or responsible party applying for registration.
Address/City/State/Zip	Give complete address of company/individual requesting registration.
Phone Number	Include area code for daytime company telephone number to contact regarding Department communications.
Type of Service	Check all boxes appropriate to the services the company may provide and/or is qualified to provide.
Name/Position	Print/type the name of the contact person and the position within the company.
Signature/Date	Contact person to sign and date.
Mail To	Radiation Control Program North Dakota Department of Health 918 E. Divide Ave, 2nd Floor Bismarck, ND 58501

SCHEDULE OF FEES FOR REGISTRATION CERTIFICATION

TYPE OF SERVICE	ANNUAL SERVICE FEES (IN DOLLARS)
X-ray Service and Installers	530
X-ray Sales and Demonstrations	530
Combined Sales and Service	700
