

**APPLICATION FOR RADIOACTIVE MATERIALS LICENSE—MEDICAL**

**INSTRUCTIONS:** Refer to *Guide for the Preparation of Applications for Medical Programs (RH 2010)*, Appendices, and *Listings of Affected Appendices to the Guide for the Preparation of Applications for Medical Programs* for more information. Complete items 1 through 28 if this is an initial application or an application for renewal of a license. Use supplemental sheets where necessary. Item 27 must be completed on all applications and signed. Retain one copy for your records. Submit original and one copy of the entire application to: California Department of Public Health, Radiologic Health Branch, MS 7610, Licensing Section, P.O. Box 997414, Sacramento, CA 95899-7414. For more information, go to [www.dhs.ca.gov/rhb](http://www.dhs.ca.gov/rhb) or phone (916) 327-5106. Upon approval of this application, the applicant will receive a Radioactive Materials License issued in accordance with the general requirements contained in Title 17, California Code of Regulations.

**NOTE: A Radioactive Materials License issued by the Department of Public Health to the applicant, pursuant to approval of the application, will contain terms and conditions based on information provided therein. Each licensee will restrict possession of licensed material to the terms and conditions of the use authorized in the license. Violation of any term and condition of the license may result in a license suspension or revocation. The terms and conditions may not be modified except by license amendment.**

1.a. Name of applicant (Institution, firm, clinic, physician, etc.)			Telephone number (     )	
Mailing address (number, street)		City	State	ZIP code
Type of business <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other (specify): _____				
1.b. Street address at which radioactive material will be used (if different from 1)	City	State	ZIP code	Telephone number (     )
2. Name of person to contact regarding this application		Title		Telephone number (     )
3. This application is for <input type="checkbox"/> New license <input type="checkbox"/> Amendment <input type="checkbox"/> Renewal of existing license—license number: _____				
4. <b>Individual Users</b> (List users and submit for each completed form RH 2000 A, a copy of board certification, or reference a previous radioactive materials license that lists the user.) <i>Note: Experience must have been received within five years.</i>				

5. **Responsible Parties** (If not provided in item 4, submit RH 2000 A or RH 2050 A.)

a. Radiation Safety Officer	Telephone number (     )
b. Chairperson of radiation safety committee ( <i>RH 2000 A or RH 2050 A, not required</i> )	
c. Custodian of sealed sources	
d. Alternate Radiation Safety Officer	

**INFORMATION REQUIRED FOR ITEM 6**

Check the appropriate boxes for the groups requested and provide the required possession limit for each group below. If necessary, attach a separate sheet and provide any additional information; include Radioactive Material, form, possession limit, and proposed use. Identify the item number and the date of the application in the lower right corner of each page.

6. <b>RADIOACTIVE MATERIAL FOR MEDICAL USE</b> (Check requested groups)	<b>Possession Limit</b> (Check requested radionuclide and/or sources when applicable.)
<input type="checkbox"/> Group 1 Diagnostic studies not involving imaging	Total not to exceed _____ mCi.
<input type="checkbox"/> Group 2 Diagnostic studies involving imaging (check one or both) <input type="checkbox"/> Unit dosage <input type="checkbox"/> Multidosage <input type="checkbox"/> Including the use of radioactive xenon as gas or gas in saline	Total not to exceed _____ mCi.
<input type="checkbox"/> Group 3 Use of radioactive materials and reagent kits for preparation of radiopharmaceuticals listed in Group 2 <input type="checkbox"/> Including the use of bulk Technetium <input type="checkbox"/> Including the use of Mo/Tc 99m and/or Rb/Kr 81m generators	Total not to exceed _____ mCi.
<input type="checkbox"/> Group 4 Internal therapy not usually requiring hospitalization (outpatient) <input type="checkbox"/> Including the use of Palliative treatment <input type="checkbox"/> Palliative treatments only	Total not to exceed _____ mCi. <input type="checkbox"/> 1131 <input type="checkbox"/> Re 186 <input type="checkbox"/> P 32 <input type="checkbox"/> Sr 89 <input type="checkbox"/> Other:
<input type="checkbox"/> Group 5 Internal therapy usually requiring hospitalization for the purposes of radiation safety (inpatient) <input type="checkbox"/> Including the use of Palliative treatment <input type="checkbox"/> Palliative treatments only	Total not to exceed _____ mCi. <input type="checkbox"/> 1131 <input type="checkbox"/> Re 186 <input type="checkbox"/> P 32 <input type="checkbox"/> Sr 89 <input type="checkbox"/> Other:
<input type="checkbox"/> Group 6 Use of sealed sources <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Sealed sources <input type="checkbox"/> Seeds <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Other:	<input type="checkbox"/> Cs 137 Total _____ mCi, in _____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Co 60 Total _____ mCi, in _____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Ra 226 Total _____ mCi, in _____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____
<input type="checkbox"/> High Dose Rate Afterloader	<input type="checkbox"/> Ir 192 Total _____ mCi, in _____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number

6. RADIOACTIVE MATERIAL FOR MEDICAL USE (continued) (Check requested groups)	Possession Limit (Check requested radionuclide and/or sources when applicable.)
<input type="checkbox"/> Medium Dose Rate Afterloader	<input type="checkbox"/> Cs 137 Total _____ mCi, in ____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Low Dose Rate Afterloader	<input type="checkbox"/> Cs 137 Total _____ mCi, in ____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Pulsed Dose Rate Afterloader	<input type="checkbox"/> Cs 137 Total _____ mCi, in ____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Ophthalmic treatments	<input type="checkbox"/> Sr 90 Total _____ mCi, in ____ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Seeds	<input type="checkbox"/> Au 198 _____ mCi in seeds <input type="checkbox"/> I 125 _____ mCi in seeds <input type="checkbox"/> Ir 192 _____ mCi in seeds <input type="checkbox"/> Pd 103 _____ mCi in seeds <input type="checkbox"/> Rn 222 _____ mCi in seeds <input type="checkbox"/> Other: _____ _____ _____
<input type="checkbox"/> Other (list)	<input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number

6. RADIOACTIVE MATERIAL FOR MEDICAL USE (continued) (Check requested groups)	Possession Limit (Check requested radionuclide and/or sources when applicable.)
<input type="checkbox"/> Group 7 Diagnostic studies involving transmission or excitation	<input type="checkbox"/> Am 241 Total _____ mCi, in ___ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> I 125 Total _____ mCi, in ___ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Gd 153 Total _____ mCi, in ___ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Group 8 Use of sealed sources for treatment of cancer <input type="checkbox"/> Teletherapy <input type="checkbox"/> Teleradiosurgery	<input type="checkbox"/> Co 60 Total _____ mCi, in ___ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Cs 137 Total _____ mCi, in ___ source(s), no single source to exceed _____ mCi Manufactured by _____ Model number _____ <input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number
<input type="checkbox"/> Group 9 Sealed or solid sources	<input type="checkbox"/> Total not to exceed _____ mCi. Each source not to exceed _____ mCi
<input type="checkbox"/> Laboratory unsealed sources	<input type="checkbox"/> List nuclide, chemical, and/or physical form and possession limit
<input type="checkbox"/> Blood irradiator	<input type="checkbox"/> Total not to exceed _____ mCi. Each source not to exceed _____ mCi Manufactured by _____ Model number _____
<input type="checkbox"/> Pacemaker devices	<input type="checkbox"/> Pu 238 Total _____ mg or _____ mCi, in _____ source(s), no single source to exceed _____ mg or _____ mCi Manufactured by _____ Model number _____
<input type="checkbox"/> Other	<input type="checkbox"/> Other (list): Source, total activity, number of sources, activity each source is not to exceed, source type, manufacturer, and model number

**INFORMATION REQUIRED FOR ITEMS 7 THROUGH 25 AND ITEM 28**

For items 7 through 25 and item 28, submit a detailed description of all the requested information. Begin each item on a separate sheet. Identify the item number and the date of the application in the lower right corner of each page. If you indicate below that an appendix to the medical licensing guide will be followed, do not submit the pages. *Applicant acknowledges changes in regulation may require the licensee to modify adopted appendices as to maintain compliance with Title 17, California Code of Regulations.*

<p><b>7. Alara Program</b></p> <p><input type="checkbox"/> Commit to Appendix A <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>	<p><b>16. a. Procedures for Maintaining Records of Radioactive Materials</b></p> <p><input type="checkbox"/> Commit to Appendix H <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p> <p><b>b. Leak Testing of Sealed Sources</b></p> <p><input type="checkbox"/> Attach detailed procedures <b>or</b></p> <p><input type="checkbox"/> Attach service contractor</p>
<p><b>8. Radiation Safety Committee</b> (Not required for private/group practice)</p> <p>a. <input type="checkbox"/> Attach names and specialties</p> <p>b. <input type="checkbox"/> Commit to Appendix B <b>or</b></p> <p><input type="checkbox"/> Attach equivalent duties</p>	<p><b>17. General Rules for the Safe Use of Radioactive Material</b></p> <p><input type="checkbox"/> Commit to Appendix I <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>9. Training and Experience</b></p> <p>a. <input type="checkbox"/> Attach form RH 2000 A for each individual user or a copy of appropriate board certification (see Appendix C)</p> <p>b. <input type="checkbox"/> Attach form RH 2000 A for RSO</p>	<p><b>18. Area Survey Procedures</b></p> <p><input type="checkbox"/> Commit to Appendix J <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>10. Instrumentation</b></p> <p><input type="checkbox"/> Attach Appendix D form <b>or</b></p> <p><input type="checkbox"/> Attach list; include types, number of each unit, ranges detected, efficiency of survey instruments, etc. (see guide)</p>	<p><b>19. Emergency Procedures</b></p> <p><input type="checkbox"/> Commit to Appendix K <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>11. Instrument Calibration</b></p> <p>a. <input type="checkbox"/> Attach Section 1 of Appendix E</p> <p>b. <input type="checkbox"/> Commit to Appendix E, Section 2, procedures survey instruments <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p> <p>c. <input type="checkbox"/> Commit to Appendix E, Section 3, procedures dose calibrator <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p> <p>d. <input type="checkbox"/> Commit to Appendix E, Section 4, procedures imaging equipment <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>	<p><b>20. Waste Disposal</b></p> <p><input type="checkbox"/> Commit to Appendix L <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>12. Facilities and Equipment</b></p> <p><input type="checkbox"/> Attach description and diagram</p>	<p><b>21. Therapeutic Use of Radiopharmaceuticals</b></p> <p><input type="checkbox"/> Attach description of dose preparation and administration</p> <p><input type="checkbox"/> Commit to Appendix M <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>13. Personnel Training Program</b></p> <p>a. <input type="checkbox"/> Attach description of training</p> <p>b. <input type="checkbox"/> Attach description of residency program</p> <p>c. <input type="checkbox"/> Attach description of preceptorship program</p>	<p><b>22. Therapeutic Use of Sealed Sources</b></p> <p><input type="checkbox"/> Attach procedures as described in item 22, a–h, of the Medical Guide</p> <p><input type="checkbox"/> Commit to Appendix N <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>
<p><b>14. Procedures for Ordering and Receiving Radioactive Material</b></p> <p><input type="checkbox"/> Attach detailed information (see Appendix F)</p>	<p><b>23. Procedures for Precautions for Use of Radioactive Gasses</b></p> <p><input type="checkbox"/> Attach information as described in Appendix O, 1–5, of the Medical Guide</p>
<p><b>15. Procedures for Safely Opening Packages Containing Radioactive Materials</b></p> <p><input type="checkbox"/> Commit to Appendix G <b>or</b></p> <p><input type="checkbox"/> Attach equivalent procedures</p>	<p><b>24. Procedures for Precautions for Use of Radioactive Material for <i>In Vitro</i> and/or Animal Studies</b></p> <p><input type="checkbox"/> Attach detailed information</p>

25. **Personnel Monitoring** (refer to 10 CFR, Part 20, Section 20.1502)

TYPE	SUPPLIER	EXCHANGE FREQUENCY
a. Whole body <input type="checkbox"/> Film <input type="checkbox"/> TLD		
b. Finger <input type="checkbox"/> Film <input type="checkbox"/> TLD		
c. Wrist <input type="checkbox"/> Film <input type="checkbox"/> TLD		
d. Internal Dose Assessment (BIOASSAY): Provide detailed information (refer to 10 CFR, Part 20, Section 20.1204)		
e. Other (specify):		

**FOR PRIVATE PRACTICE APPLICANTS ONLY**

26. **Hospital Agreement to Accept Patients Containing Radioactive Material**

Name of hospital

Mailing address (street, number)

City

State

ZIP code

Attach a copy of the agreement letter signed by the hospital administrator

27. **Certificate**

(The individual executing this certificate must have the authority to commit the applicant relative to matters involved in this application.)  
The applicant and any official executing this certificate on behalf of the applicant named in item 1.a. certify: ***This application is prepared in conformity with the California Code of Regulations and all information contained therein, including supplements attached thereto, are true and correct to the best of my knowledge and belief.***

Applicant or certifying official name (type or print)

Title

Tax Identification Number

Signature

Date

28. **Financial Assurance** (See Title 17, California Code of Regulations, Section 30194(g).)

**Attach one of the following:**

- Decommissioning Funding Plan
- Certification of financial assurance for decommissioning
- Statement of Intent (state or local government licensees)
- Rationale for exemption

**NOTE: This application will not be processed if the above information has not been provided.**

The information you are asked to provide on this form is requested by the California Department of Public Health, Radiologic Health Branch. This notice is required by Section 1798.17 of the Information Practices Act of 1977 (Code of Civil Procedure, Section 1798-1987.76) and the Federal Privacy Act to be provided whenever an agency requests personal or confidential information from any individual. It is mandatory that you furnish the information requested on this form. Failure to furnish the requested information may result in an inaccurate determination of statements and/or disapproval of your application.