

## Application for Mammography Machine Certification

### SECTION 1 – FACILITY STATUS

Type of mammography facility (check one):

Screening/Diagnostic

Interventional Only

Other (specify)

Reason for this application (check all that apply):

New Facility\*

New Machine\*

Ownership Change\*

Name Change\*

Address Change\*

Personnel Change

Renewal

Reinstatement

Other (specify)

**\*Requires submission of a [Radiation Machine Registration Form](#)**

Provide registration form tracking number:

State Registration Number FAC:

Expiration Date:

State Mammography Certificate(s) Expiration Date:

FDA Facility Identification Number:

FDA Certificate Expiration Date:

### SECTION 2 – FACILITY INFORMATION

Facility Name:

Doing Business As (DBA):

Facility Physical Address

Street:

City:

Zip:

Facility Mailing Address (if different from above)

Street:

City:

State:

Zip:

Facility Contact Person

Name:

Phone:

E-mail:

Secondary Contact Person

Name:

Phone:

E-mail:

**Section 3 – Mammography Personnel**

**Physicians.** List all physicians who interpret mammography exams for this facility. Use additional sheets if necessary.

- Name (First, MI, Last): Lead Supervising Physician  
Supervisor/Operator Certificate/Permit Number:  
Certificate/Permit Expiration Date:
- Name (First, MI, Last): Lead Supervising Physician  
Supervisor/Operator Certificate/Permit Number:  
Certificate/Permit Expiration Date:
- Name (First, MI, Last): Lead Supervising Physician  
Supervisor/Operator Certificate/Permit Number:  
Certificate/Permit Expiration Date:
- Name (First, MI, Last): Lead Supervising Physician  
Supervisor/Operator Certificate/Permit Number:  
Certificate/Permit Expiration Date:

**Technologists.** List all mammography technologists for this facility. Use additional sheets if necessary.

- Name (First, MI, Last): QC Technologist  
Mammography Technologist Certificate Number: RHM  
Certificate Expiration Date:
- Name (First, MI, Last): QC Technologist  
Mammography Technologist Certificate Number: RHM  
Certificate Expiration Date:
- Name (First, MI, Last): QC Technologist  
Mammography Technologist Certificate Number: RHM  
Certificate Expiration Date:

**Section 4 – Mammography System Information**

List all active machines at location. Use additional sheets if necessary.

New Machine Certificate Applications: List new mammography machine(s) only.

Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_  
Serial Number: \_\_\_\_\_ Room Name or Number: \_\_\_\_\_  
MAP-ID Number: \_\_\_\_\_  
Manufacturer and Model of Image Receptor or Add-on DBT: \_\_\_\_\_  
Use:            Mobile\* (see page four)            Screening/Diagnostic            Interventional            Research  
Modality:            FFDM            DBT            Other

Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_  
Serial Number: \_\_\_\_\_ Room Name or Number: \_\_\_\_\_  
MAP-ID Number: \_\_\_\_\_  
Manufacturer and Model of Image Receptor or Add-on DBT: \_\_\_\_\_  
Use:            Mobile\* (see page four)            Screening/Diagnostic            Interventional            Research  
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Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_  
Serial Number: \_\_\_\_\_ Room Name or Number: \_\_\_\_\_  
MAP-ID Number: \_\_\_\_\_  
Manufacturer and Model of Image Receptor or Add-on DBT: \_\_\_\_\_  
Use:            Mobile\* (see page four)            Screening/Diagnostic            Interventional            Research  
Modality:            FFDM            DBT            Other

**Film Processor.** List if any. Use additional sheets if necessary.

Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_  
Location: \_\_\_\_\_ For which machine named above:

**Additional Requirements for Mobile Machines.**

Attach a separate sheet specifying the following for each machine.

- The physical address of each location where mammography will be performed;
- The name and telephone number of the responsible person who is allowing the service to be provided at the location;
- Whether mammograms will be processed with an on-board processor or, if processed at different locations, the address of each location;
- Whether the machine is fixed or used, exclusively, in a mobile vehicle or if transported to the use location and moved to the area examinations are to be performed, the designated room within the building at each use location; and
- A description of the quality assurance tests that will be performed each time the machine is relocated.

**Section 5 – Medical Physicist Report**

Attach the latest complete report of a mammography system evaluation performed less than 6 months prior to the date of the application for a new machine or a report of a survey performed less than 12 months prior to the date of the renewal application. If any failures and/or recommendations are referenced in a report, attach a list of corrective actions taken to mitigate all deficiencies and the date corrections were achieved. Include copies of work invoices with the description of corrective actions taken. Incomplete physicist's reports or reports with deficiencies that are not addressed will not be accepted.

**Section 6 – Acknowledgment and Certification**

I declare under penalty of perjury under the state law of California that the information submitted on this form with its attachments to be true and correct, and I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation source(s) for which I am applying.

**User Signature:****Name:****Date:****Phone Number (if different from Section 2):**

If the individual who signed above is not the Lead Supervising Physician, the following information must be completed: As the Lead Supervising Physician responsible for mammography operations at this facility, I concur with all representations in this application.

**Lead Supervising Physician Signature:****Name:****Date:****Phone Number (if different from Section 2):****Section 7 – Submit Application****E-mail:**[RHBRMT@cdph.ca.gov](mailto:RHBRMT@cdph.ca.gov)**Mail:**

California Department of Public Health, Radiologic Health Branch  
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