RADIOLOGIC TECHNOLOGY SCHOOL AFFILIATED CLINICAL SITE

This form shall be submitted prior to approval of each new affiliated clinical site (ACS). Use this form to notify the Department of any changes regarding affiliated clinical sites.

☐ **New** ☐ **Change** ☐ **Discontinue**

[A] School Information

Name of School	School Identification Number

[B] Facility (Affiliated Clinical Site) Information

Current Facility Registration Number		Expiration Date	
Current Facility Name as Registered with CDPH-RHB			Telephone Number
Current Address (physical location of facility)		City	ZIP Code
Facility Contact Name (**new requests only**)	Email		Telephone Number
Previous Facility Registration Number (if applicable)			
Previous Facility Name as Registered with CDPH-RHB (if applicable)			Telephone Number
Previous Address (if applicable)		City	ZIP Code

[C] Limited Permit Schools, indicate permit category(ies) requested for clinical training:

☐ Chest	☐ Extremities	☐ Torso-skeletal	☐ Skull	☐ Leg-podiatric	☐ Dental laboratory	☐ DEXA

[D] I attest that the information on this form is true and correct.

Name of Designated School Official	Title
Signature of Designated School Official	Date

Email completed form and supporting documentation to your assigned School Certification Unit Staff member or the general mailbox for the School Certification Unit at rhbschools@cdph.ca.gov