RADIATION MACHINE REGISTRATION FORM FOR WITHDRAWAL OF REGISTRATION

Please read the instructions before completing this form.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)	Registration Number	☐ Mammography Provider

Physical Address (street number and name)	City	State	Zip Code

B: REASON FOR WITHDRAWAL Check the appropriate box. See instructions for details.

☐ Registrant is no longer in possession of any radiation machines.

☐ All radiation machines that the registrant is in possession of have been made incapable of producing radiation.

C: WITHDRAWAL DATE

D: SIGNATURE OF AUTHORIZED REPRESENTATIVE

I declare under penalty of perjury under the laws of the State of California that the information submitted on this form and on any attachments is true and correct. I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation machine(s) for which I am applying.

Name	Title/Position	Signature
E-mail Address	Phone Number	Date

E: RECORDKEEPING/SUBMISSION Keep a copy for your records. Do not submit multiple copies of the same completed form. Mail the original with supporting documents to:

If sending by regular mail, send it to	**If sending by express mail, send it to**
Registration and Certification Support Unit California Department of Public Health Radiologic Health Branch, MS 7610 P.O. Box 997414 Sacramento, CA 95899-7414	Registration and Certification Support Unit California Department of Public Health Radiologic Health Branch 1500 Capitol Avenue, 5th Floor, Building 172 Sacramento, CA 95814-5006

For more information, please visit our website at http://cdph.ca.gov/rhb or call (916) 327-5106.

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