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SECRETARY

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INTERIM COMMISSIONER

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Environmental Health
Radiation Control Program
Schrafft Center, Suite 1M2A
529 Main Street, Charlestown, MA 02129
(617) 242-3035 (617) 242-3457 - Fax

Registration Termination Form

Disposition of Medical X-Ray Unit(s)

Facility Name: _____

Address: _____

_____

Telephone Number: _____

Radiation Control Number (RCN): _____

The following information is provided in accordance with 105 CMR 120.030: "Report of Changes". Complete the items below which are applicable to your registered unit(s).

1. The x-ray unit(s) authorized under the above referenced RCN # has been terminated. Attached is a copy of the receipt from the service provider that removed the unit(s).

2. The x-ray unit(s) was disposed of in the following manner: (please circle)
   (A.) Cut the x-ray cord
   (B.) Took to town's hazardous waste site

3. The x-ray unit(s) were transferred to:
   Name: _____
   Address: _____
   Telephone Number: _____

I, the owner of the x-ray unit(s), hereby certify that the x-ray unit(s) is no longer in my possession and request that the above referenced Registration be terminated.

Date: _____

Signature: _____

Title: _____