INSPECTION OF DENTAL RADIOLOGICAL EQUIPMENT

RADIOLOGICAL HEALTH PROGRAM (907) 334-2107

doh.radiation.control@alaska.gov

FORM MUST BE COMPLETED AFTER ANY EQUIPMENT SERVICE OR INSPECTION WHICH EFFECTS THE TUBE OR IMAGE QUALITY OF THE DEVICE

Note: Minor repairs to devices are not to be listed on this form

PART I. DEVICE STATUS:

☐ **ANNUAL SERVICE** ☐ **INITIAL INSTALL** ☐ **REPAIR** ☐ **OTHER** _____

PART II. FACILITY INFORMATION:

REGISTRATION NUMBER: _____ **Primary dentist license #** _____

NAME OF BUSINESS: _____

OR Doing-Business-As: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____

POINT OF CONTACT: _____

FAX/E-MAIL ADDRESS: _____

PART II. ALL DEVICE(S) MUST BE EVALUATED IN ACCORDANCE TO REGULATIONS (PART F) & MANUFACTURER RECOMMENDATIONS: The following minimum conditions must be checked for the appropriate device used at a facility (refer to the regulations and/or request a DOH equipment inspection guide). All device parameters must be recorded on a separate document showing each measurement for each device evaluated. Refer to Part III below.

- ✓ Device is registered
- ✓ Radiation leakage from source tube
- ✓ Aluminum equivalent measurement
- ✓ Mechanical support of tube head
- ✓ Radiation exposure control
- ✓ Backscatter shields on handheld
- ✓ Kilovolt peak
- ✓ Termination of exposure
- ✓ Provider qualified
- ✓ Air kerma emitted
- ✓ Fluoroscopic filtration
- ✓ Multiple tubes
- ✓ Exposure initiation
- ✓ Beam on indicators
- ✓ Beam alignment
- ✓ Tomographic plane (CT)
- ✓ Quality assurance measurements
- ✓ Technique factor
- ✓ Battery charge indicator
- ✓ Source to skin distance
- ✓ Exposure position
- ✓ Exposure reproducibility
- ✓ Device accreditation (CT)
- ✓ Other checks as required
- ✓ Warning label
- ✓ Beam quality (HVL)
- ✓ Modified components
- ✓ Locks
- ✓ Dark room
- ✓ Timer
- ✓ Shutter check (CT)

PART III. RADIATION PRODUCING EQUIPMENT: Devices requiring installation, evaluation, or preventative maintenance must include the following device identification information and all applicable measurements described in Part II above: Manufacture, Model, Serial Number, and Device Type (such as CT, CBCT, PANO, intra-oral, etc.) **DEVICE PARAMETERS MUST BE RECORDED ON A SEPERATE DOCUMENT SHOWING EACH MEASUREMENT FOR EACH DEVICE EVALUATED. EACH DEVICE MUST STATE A PASS OR FAIL RATING AND ANY CORRECTIVE ACTIONS, IF FAILED. ATTACH ALL DOCUMENTS RECORDING MEASUREMENTS TO THIS FORM.**

PART IV. CERTIFICATION OF QUALIFIED SERVICE PROVIDER/VENDOR/OR INSPECTOR: THIS IS TO CERTIFY THAT, I, THE DELEGATED AUTHORITY, TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN, INCLUDING ANY SUPPLEMENTS ATTACHED HERETO, IS CORRECT AND MEETS THE REQUIREMENTS OF THE SUGGESTED STATE REGULATIONS-PART F- PUBLISHED BY THE CONFERENCE OF RADIATION CONTROL PROGRAM DIRECTORS (CRCPD).

PRINT NAME: _____ SIGNATURE: _____

COMPANY NAME _____ Date: _____

COMPANY EMAIL ADDRESS & PHONE # _____