DEPARTMENT OF ENVIRONMENTAL QUALITY
OFFICE OF ENVIRONMENTAL COMPLIANCE
RADIATION SECTION
POST OFFICE BOX 4312
BATON ROUGE, LOUISIANA 70821-4312
PHONE: (225) 219-3041
E-MAIL: LDEQRadiationlicensing@la.gov

Office Use Only
APPLICATION
AI
Registration No.
Shielding Date

APPLICATION FOR REGISTRATION OF RADIATION SOURCE

DRC-6 (Rev. 6/2026)

Must check all that apply:
☐New Registration ☐ Shielding Evaluation Information (see pg 2) ☐ If replacing old machine enter old Registration # _____
☐Change of Address or other Information (see pg 3) ☐ Disposition of Equipment, ie. required information if this unit replaces an existing one (See pg 4)

FACILITY INFORMATION

1. Company Name/Facility Name		2. Name of Owner	
3. Mailing Address: No., Street, Ste.	City & State	Zip Code	4. Contact Email Address
5. Billing Address: No., Street, Ste.	City & State	Zip Code	6. Area Code-Telephone Number of Facility
7. Full Address at which x-ray unit will be used	City & State	Zip Code	8. Room No. & Location where source will be used

9. Type of Facility

☐ Hospital (IM) ☐ Medical Clinic (PM) ☐ Private Medical Practice (PM) ☐ Educational Institution (ED)
☐ Industrial (IN) ☐ Industrial Radiography (IR) ☐ Private Dental Practice (PD) ☐ Medical Mobile Imaging (PM)
☐ Veterinary (VT) ☐ Chiropractic (DC) ☐ Dental Clinic (PD) ☐ Other (Specify):_____

USER INFORMATION

10. Individual in Charge of Source (RSO, operator, etc.)	11. Individual Responsible for Radiation Protection

12. Classification of Individual in Charge of Source

☐ Dentist ☐ General Practitioner ☐ Health Physicist ☐ Registered X-Ray Technologist
☐ Radiologist ☐ Industrial Radiographer ☐ Veterinarian ☐ Non-Registered X-Ray Tech.
☐ Chiropractor ☐ Podiatrist ☐ Osteopath ☐ Other (Specify):_____

SOURCE INFORMATION

13. Source (Check all that apply)

A. Medical X-Ray
☐ Fluoroscopic
☐ Radiographic
☐ Photofluorographic
☐ Mammography
☐ CT
☐ CT For Non-Diagnostic Use Only
☐ Combination (Radiographic & Fluoroscopic)
☐ Bone Densitometer
☐ Deep Therapy
☐ Superficial Therapy
☐ Special Procedures

B. Dental X-Ray
☐ Conventional
☐ Panoramic
☐ Cephalometric
☐ CBCT (see shielding pg 2)

C. Accelerator
☐ Linear Accelerator
☐ Cyclotron
☐ Other (Specify): _____

D. Other X-Ray
☐ Industrial Radiography
☐ Diffraction Apparatus
☐ Cabinet
☐ XRF
☐ Other (Specify): _____

E. Educational Institution
☐ Medical X-Ray
☐ Dental X-Ray
☐ Other X-Ray

F. Veterinary
☐ Radiographic
☐ Dental

14. Source is: ☐Fixed ☐Mobile ☐Handheld (If handheld, attach training documentation from the manufacturer)

15. **Control Panel Information (Use one form for each panel):** *Use only information from Control Panel*

a. Manufacturer	b. Model Number	c. Serial Number	d. Number of Tube Heads	e. Max. kVp	f. Max. mA

CERTIFICATION

16. This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

Date | Primary Contact Person (Print) | Applicant (Print) | Signature of Responsible Party

Submit the completed original application for each x-ray unit to the above address or email LDEQRadiationlicensing@la.gov, and maintain a copy for your files.

Shielding Evaluation Information

LAC 33:XV.603.E. Plans Review

1. Except for dedicated mammography radiographic systems, podiatric radiographic systems, panoramic dental radiographic systems, and intraoral dental radiographic systems, prior to construction, the floor plans and equipment arrangement of **all new installations, or modifications of existing installations, utilizing X-rays for diagnostic or therapeutic purposes shall be submitted to the Office of Environmental Compliance for review and approval.** The required information is specified in LAC 33:XV.699.Appendices A and B.
2. The floor plans and equipment arrangement for all new, or modifications of existing, installations for veterinary X-ray systems shall be reviewed for adequacy by the department on a case-by-case basis.

If shielding is required for X-ray unit and has already been approved by the Department, ***please attach a copy of the approval letter****. If letter is not available, submit the following information:*

Room Housing Unit (Description or Room Number):	Date of the Department approved shielding:	☐Shielding review form enclosed ☐Shielding review form recently submitted and waiting for approval

If the machine to be registered requires shielding and it is replacing an old machine that already had a shielding review done or it is a ***CBCT unit****, please submit the following information:*

Average # of Patients/week:	Average kVp used:	☐Room has not changed since last approved shielding review ☐Room has changed since last approved shielding review (please enclosed description of changes) ☐CBCT Unit is placed in a room

If the above information is not available, please submit a physicist survey

☐Physicist Survey included
☐Physicist Survey not included

For CBCT units, please submit training certificate(s) and Quality Assurance Plan

Please provide any other detailed information that will assist the department in registering your machine(s).

_____

_____

_____

_____

_____

Transfer Information

If facility/machines were transferred from a different location that the registrant owns, please provide the following information for ***the previous location, the new location, and which machines are being transferred.***

PREVIOUS FACILITY INFORMATION		
1. Company Name/Facility Name	2. Name of Owner	3. Agency Interest No., if known
4. Full Address at which x-ray was located:	5. Telephone Number of Facility	6. Contact Email Address

NEW FACILITY INFORMATION			
1. Company Name/Facility Name		2. Name of Owner	3. Agency Interest No., if known
4. Mailing Address: No. & Street	City & State	Zip Code	5. Contact Email Address
6. Billing Address: No. & Street	City & State	Zip Code	7. Area Code – Telephone Number of Facility
8. Address at which x-ray is located:	City & State	Zip Code	9. Date of Transfer

SOURCE INFORMATION

Control Panel Information **(Use a separate page for additional units):** *Use only information from Control Panel*

a. Manufacturer	b. Model Number	c. Serial Number	d. Type of Machine

NOTE: *For any unit that requires shielding, please refer to Shielding Evaluation Information (page 2) for the new location.*

CERTIFICATION

This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

Date	Primary Contact Person (Print)	Applicant (Print)	Signature of Responsible Party

NOTE: All applications must be signed and dated before a Registration Certificate can be issued.

DEPARTMENT OF ENVIRONMENTAL QUALITY
OFFICE OF ENVIRONMENTAL COMPLIANCE
RADIATION LICENSING SECTION
POST OFFICE BOX 4312
BATON ROUGE, LOUISIANA 70821-4312
PHONE: (225) 219-3041
E-MAIL: LDEQRadiationlicensing@la.gov

Office Use Only
AI
Registration No.
Activity No
Fiscal Status

RADIATION MACHINE DISPOSITION FORM

To terminate an x-ray registration and avoid paying the annual fee for a radiation machine that is no longer in your possession or inoperable in the manner described below, the following information must be received by the department by the invoice due date. (LAC 33:XV.213.D and LAC 33:XV.2508.D-E)

1. This application is for:

☐ Termination of Entire Facility Registration (must complete a form for each machine) ☐ Machine Removal Only ☐ Machine Removal and Replacement (must complete DRC6 for new machine)

2. Registrant Information: Facility AI Number: _____

Company Name: _____

Physical Address: _____

Contact Name: _____

Contact Phone Number: _____ Contact E-Mail: _____

3. Machine Information: Registration Number: _____ EQT Number: _____

Manufacturer: _____

Model Number: _____

Serial Number: _____

4. Machine Status: (select all that apply and complete/attach all information)

Machine is: ☐Operable ☐Inoperable Date of Change: _____

(A machine is inoperable only if the machine's X-ray tube (insert) has been removed in such a manner that it would require an X-ray company/service person to make it operable. With the X-ray tube in place, the unit is considered to be operable.)

☐Disassembled/removed/scrapped (Attach documentation from service company, recycle company, manufacturer, etc. or list company information below.)

☐Transferred/Sold/Donated

Company Name: _____

Address Transferred to: _____

Contact Name: _____

Contact Phone Number: _____ Contact E-mail: _____

☐Other Information for Termination Request:

5. CERTIFICATION:

This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

Date | Printed Name of Responsible Party | Printed Title | Signature of Responsible Party