State of Hawaii
Department of Health

APPLICATION FOR RADIATION FACILITY LICENSE

License is required by Title 11, Administrative Rules, Department of Health, Chapter 45, Radiation Control.

Part I. Doing-Business-As (DBA)			Part II. Business Information (i.e. Inc., LLC)		
Name of Facility:			Name of Facility:		
Street Address:			Street Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Mailing Address:			Mailing Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Phone:	Fax (Optional):		Phone:	Fax (Optional):	
E-Mail Address (Optional):			E-Mail Address (Optional):		

Part III. Responsible Personnel (attach additional sheets as needed)	
Facility Compliance Contact (Required):	Facility Inspection Contact:
Person Responsible for Radiation Safety (Required):	Other:

Part IV. Radiation Producing Equipment (attach additional sheets as needed)

Manufacturer/Make:	Control Model No.:	Control Serial No.:	Control Manufacture Date:	Location:	Purpose/Use (Diagnostic/Screening/Etc.)

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Part V. Radiation Facility License Fee Schedule

Indicate all categories for which a license is requested:

	Category	Fee
☐	Chiropractic x-ray facility	$50
☐	Dental x-ray facility with 1-4 units	$30
☐	Dental x-ray facility with 5+ units	$50
☐	Industrial radiography (electronic)	$50
☐	Medical x-ray facility with 1-4 units	$50
☐	Medical x-ray facility with 5-7 units	$100
☐	Medical x-ray facility with 8+ units	$150
☐	Podiatry x-ray facility	$30
☐	Radiation therapy facility	$100
☐	Veterinary x-ray facility	$30
☐	Other radiation facility not listed	$30

RADIATION FACILITY LICENSE FEE: $

****** For facilities with multiple categories, the license fee shall be the fee for the single highest dollar value category.***

I declare that all the information appearing on this application is accurate and true to the best of my knowledge.

X______________________________________ ______________________________________

Signature of facility owner / lessee / user / authorized agent **Print Name/Position**

____

Date

Please make checks payable to: ***STATE DEPARTMENT OF HEALTH***

Return this application with the appropriate attachments to:

Indoor and Rad Health Branch
99-945 Halawa Valley Street
Aiea, Hawaii 96701

All fees are non-refundable. There will be a service fee of $25.00 for any check dishonored by the bank.
If you have any questions call our office at (808) 586-4700.

FOR OFFICE USE ONLY:

Date Received: ______ Fee Paid $ ______ Receipt Number: ______

License(s) Number(s):

Chiropractic		Podiatry	
Dental		Therapy	
Hospital		Veterinary	
Industrial		Other	
Medical			

APPLICATION: APPROVED / DISAPPROVED

LICENSE EXPIRES:

REVIEWED BY: ______ DATE: ______

Form IRHB-RAD100A.3 06/16