Kansas Department of Health and Environment (KDHE)
RADIATION CONTROL SECTION
Website: www.kdheks.gov/radiation/index.html
Ref: K.A.R. 28-35-167 through 169

INFORMATION REQUIRED FOR AN X-RAY RADIATION SHIELDING PLAN REVIEW

Please complete and include this form with your x-ray room plans and specifications and submit to the address at the bottom of page 2. Please call if there are any questions. Additional technical information on shielding can also be obtained by contacting the National Council on Radiation Protection and Measurements (NCRP), phone 301-657-2652 or online at www.ncrponline.org

Facility Information:

Registration Number (if it has been assigned by KDHE): _____

Name of proposed user and owner of x-ray equipment: _____
_____

Installation location:
Business/FacilityName:_____
Address: _____
Phone/Fax #: _____
E-Mail: _____
Room #'s: _____
(Provide the address where we should send our review of your plan if it is different than the address of the proposed installation.) _____

Type of facility (circle one):
Hospital M.D./D.O. (including clinics, surgery centers, pain management, weight loss, etc.) DDS
Podiatry Veterinary Chiropractic Industrial Educational
Public Facility Other (list)_____

Type of machine (circle all that apply):
Radiographic Fluoroscopic (fixed and mobile c-arms) Radiographic/Fluoroscopic CT
Mammography Cardiac Cath Angiography Dental
Bone Mineral Densitometry Linear Accelerator Educational Analytical Security
Other(list)_____

Please answer all questions for each room. Make copies of this form for more than one room.

Make and model of the x-ray generator control: Room #:_____
Manufacturer: _____
Model #: _____
Serial #: _____

Maximum mAs used per procedure: _____

OR maximum mA_____ per procedure and maximum exposure time in seconds per procedure_____

OR maximum on-time of x-ray beam per procedure in sec./min./hrs.(circle and list amount)_____

Maximum kVp used per procedure: _____

Type of procedures which will be performed with the equipment: (chests, spines, abdomens, whole body CT, special procedures, cardiac cath, dental, treatments, analytical, measurement, metal/foreign body detection, security, etc.)

_____

_____

Workload: Average number of procedures or exposures per week: _____

Please provide a floor plan that shows, at a minimum, the following for each room or device**:**
(You may use the graph paper provided on page 3 or provide your own layout form/architectural drawing.)

a) the normal location of the x-ray system's radiation port or diagnostic tube
b) the port or diagnostic tube housing's travel and traverse limits
c) the directions of the useful x-ray beam
d) the locations of any windows and doors
e) the location of the operator's booth
f) the location of the x-ray control panel
g) the dimensions of each room concerned

What is the structural composition, thickness or lead equivalent of each room concerned: (Indicate primary or secondary barrier)**.** Primary barrier is a wall/floor that the direct x-ray beam strikes. Secondary barrier is a wall/floor that secondary/scatter radiation strikes.

Walls:_____
Doors:_____
Partitions:_____
Floor:_____
Ceiling:_____

What is the type of occupancy factor* of each adjacent room/area, inclusive of space above and below the rooms concerned. If there is an exterior wall, please show on floor plan or write the distance to the closest areas where it is likely that individuals may be present:

_____

_____

_____

_____

_____

_____

*(i.e., is public access "controlled" by you or is it "open and freely available" to the general public? Is it continuously occupied or what percentage of the time is it occupied?).

Name/address/phone#/email of the qualified expert, medical/health physicist, or other, which may have computed the shielding requirements, including all basic assumptions and recommendations.

_____

_____

_____

Submit x-ray room plans and specifications with this completed form to:
Kansas Department of Health and Environment
Bureau of Environmental Health, Radiation Control Section
1000 SW Jackson, Suite 330, Topeka, KS 66612-1365
Phone 785-296-1560, 785-296-0984 (fax)

ROOM(S) DRAWING (use additional copies if necessary)

NAME:_____

ADDRESS:_____

ROOM # OR MACHINE NAME OR MODEL #:_____