FLUOROSCOPIC X-RAY MACHINE SHIELDING

Please provide all information requested:

Facility Name:____

Address ______________________ Room ______________________
______________________ Contact ______________________
______________________ Telephone ______________________
______________________ Fax ______________________
Email ____

X-ray Machine: Manufacturer______________________________
Model____________________________________
Maximum kVp_______________

Patient Workload: (Use Maximum Projected Workload Figures)

Fluoroscopic	No. of Exams/Week	Fluoro Time/Exam

Room Layout: ¼" scale drawing with location of X-ray machine.

For the following, mark all that apply. If there is occupied space above or below the room, please indicate the floor-to-floor (FTF) height and the thickness of concrete (if any) in the floor or ceiling.

- ☐ Single story building
- ☐ There is occupied space above room. FTF: ________ Conc.: ________
- ☐ There is occupied space below room. FTF: ________ Conc.: ________

Results To: ______________________ Bill To: ______________________
______________________ ______________________
______________________ ______________________
Attn: ______________________ P.O. # ______________________
Email: ______________________

***Payment required prior to releasing the report.**
Reports are provided within 14 business days after all required information is received.

7525 SE Lake Road
Milwaukie, Oregon 97267
PH: 503-620-6617
FX: 503-684-5548
shielding@hpnw.com

Date Received: ____________
Job Number: ____________

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