HPNW
HEALTH PHYSICS NORTHWEST

MAMMOGRAPHIC 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)*

No. of Exams/Week	No. of Exp./Exam	Average mAs/Exp.

- **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: _____ PO #: _____
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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