



RADIOGRAPHIC 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)

Radiographic	No. of Exams/Week	No. of Exp./Exam	Average mAs/Exp.
Table Exams			
Chest Exams			
Other Lateral Exams			

Room Layout: ¼" scale drawing with location of X-ray machine and wall or upright bucky.

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: _____

**Note: Billing terms are NET 30.
 Reports are provided within 14 business days
 after all required information is received.**