HPNW
HEALTH PHYSICS NORTHWEST

# 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 | | | |
| Upright 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: _____

***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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