



VETERINARY 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			

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: _____